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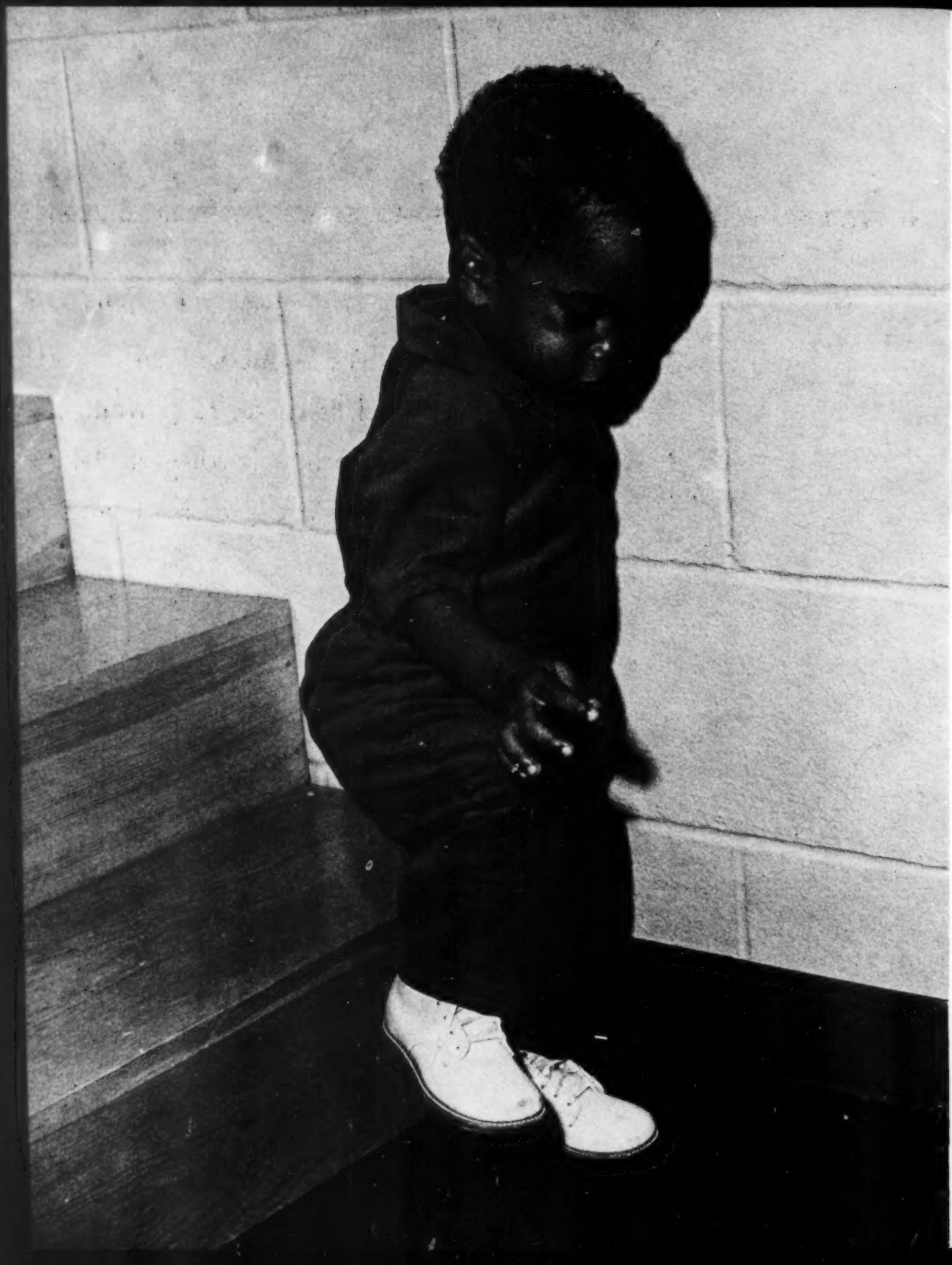

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Making it downstairs in an upright position is one of the major accomplishments of early childhood, as this toddler's concentration on the task suggests. A participant in an "early intervention" program to stimulate various aspects of development, the child was photographed during a test of his motor skills and coordination. On the next page another child in the same program is learning from his father how to hold a cup by the handle. Some thoughts on the ethical considerations in intervention research are offered in the accompanying article.

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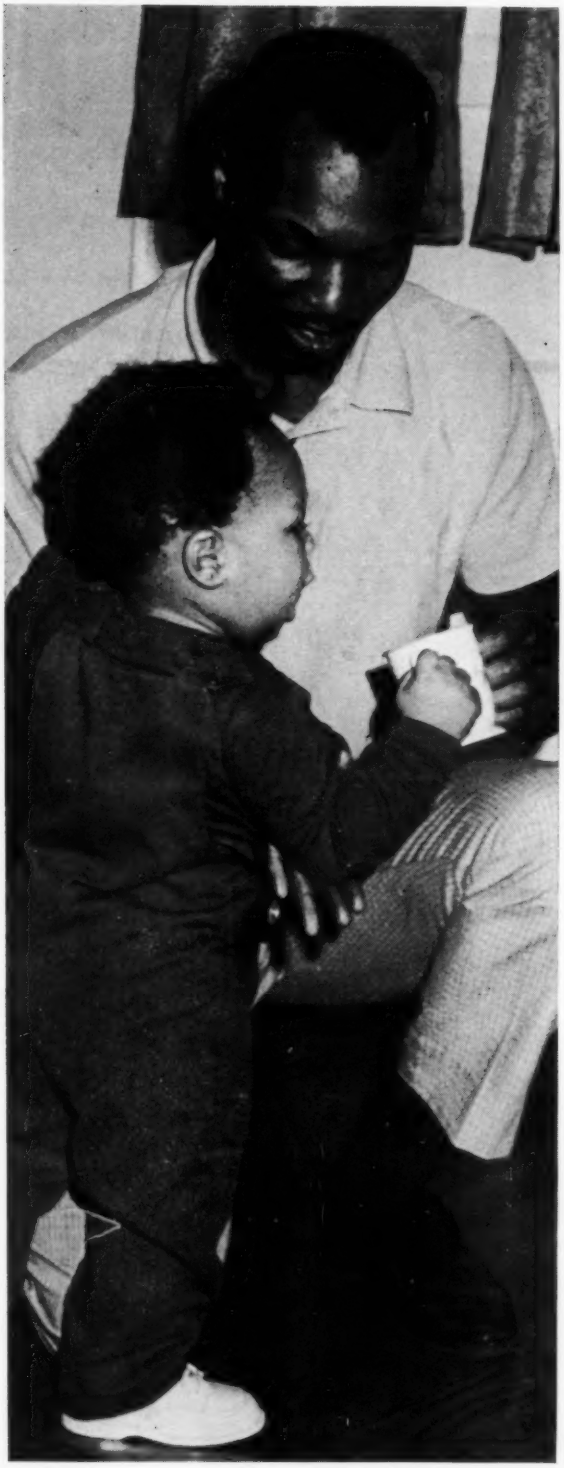

ETHICAL ISSUES in RESEARCH in EARLY CHILDHOOD INTERVENTION

SUSAN W. GRAY

In a sense this paper represents an extension of an article by M. Brewster Smith about value conflicts in behavioral research with children that appeared in CHILDREN 3 years ago,[1] since its purpose is to examine the ethical issues involved in research on the effects of planned intervention early in a child's life. In another sense, however, I am presenting here a somewhat personal account of over a decade of involvement in intervention research with young children from low-income families. In the past decade my colleagues and I have moved from a time in which intervention research on low-income children was seen as a somewhat aberrant interest for psychologists through a time in which we were seen as in the forefront of a brave new social movement, to a time in which the desirability of our work is seriously questioned in some quarters. The wide attention given to the Jensen article in the *Harvard Educational Review* [2] and the Westinghouse Report, "The Impact of Project Head Start," [3] is indicative of the public's interest in programs of intervention as well as of some feelings of disillusionment.

My own first contact with the field of intervention research was a brief one in the summer of 1959. Several of us at Peabody College for Teachers who were concerned with school psychology planned a summer kindergarten experience for black children from low-income families to be given just prior to their entrance to the first grade of school. In a sense our approach was not casual. We carefully reviewed the relevant literature on social class and on child development; we planned the children's experiences in the program in great detail; we carefully selected as lead teacher a black woman who was an exceptionally gifted first grade teacher. But we failed to question the general appropriateness of the study or to consider the possible harm our intervention might do to the child or his family.

Within the next 2 years Rupert Klaus and I began a much more extended study, the Early Training Project,[4] which required us to face up to these questions and to many more. It involved intensive work with young children in the two or three summers prior to their school entrance. Included as a bridge from one summer to the next was a series of weekly visits to the home during the year.

As we began the study, I consulted two of my wisest and most experienced colleagues in regard to ethical considerations. Fearing that our avowed goal of changing the children's attitudes towards school and school-type activities might create a distance between the two generations, we planned to spend a large proportion of our time working with parents, helping them understand what we were doing and encouraging them to take part in the process. Still we were concerned about whether we were engaged in a bit of middle-class brainwashing.

Our social-psychologist colleague assured us that, with the particular technique we were using, we had

little need to worry. He thought it unlikely that the study would result in any profound attitude change. Experience has taught most social psychologists that changing values and attitudes is an extremely difficult thing to do.

To our clinical-psychologist colleague we posed the question: Were we making these children dissatisfied with their own lot in life? At that time the small town in which they lived had few opportunities for black people to move upward. He replied that our project was an act of our faith that the future would hold more opportunities for these children than had been available to such children in the past.

Thus reassured, we began the Early Training Project. But in conducting the study, we carefully tried to avoid any negative effects of the kind that had been worrying us.

In the decade since the beginning of the Early Training Project my colleagues and I have in one way or another identified many of the ethical issues that impinge on educational and psychological research in this area. We have talked about these issues with the workers who are in direct contact with the mothers and children in our studies, with others working in intervention research, and with persons engaged in other types of behavioral research. In discussing the issues here, I will also present some thoughts about research on human subjects in general drawn from the deliberations of the American Psychological Association Committee on Ethics in Research with Human Subjects.[5]

Intervention research, however, imposes some special characteristics of its own. It is necessarily longitudinal—that is, it takes place over a considerable period of time. Typically many changes, some intentional and others not, are introduced into the system—the child and his world. The objectives are apt to relate to motivational characteristics and also to various facets of intellectual competence. Thus, the program may touch not only the persons who are its specific targets but also those with whom they live and associate. The effects are intended to be lasting and substantial. Inevitably, much intervention research has a fairly strong service orientation and thus runs into the demands and expectancies of direct service programs. Finally, because intervention research touches many social and educational concerns, it is a highly sensitive area.

Questions and criticisms

A decade ago developmental "interveners" were seldom questioned about their motives and general intentions. It was usually taken for granted that a program that had clear implications for human welfare originated from positive motives. Today questions arise, particularly from members of minority groups, concerning such motivation. The majority of these questions have little to do with methods of research, but rather with intervention as such, whether in a service or a research program. Nevertheless, intervention researchers must take these questions into account.

Some objections center on the rights of parents. There is certainly no question from the legal standpoint that the parent is completely responsible for the child and has a full right to grant or withhold consent for the preschool child's participation in any program—up to a point. This point may be reached in extreme cases of a medical need, as when a parent refuses a transfusion or an immunization in the face of clearcut danger to the child's life. The more difficult question perhaps is whether the parents' rights extend to decision-making with respect to the intervention program itself and include the right to dictate the program's methods and goals. This is not an easy issue to resolve. I shall return to it further on.

Other questions go beyond the parents' rights. One criticism leveled at developmental interveners these days is often put this way: How do you dare to work simply with young children when the basic problem is the entire social system?

This question, of course, implies a certain lack of distinction between a child development worker's professional role and his civic role. Asking a developmental intervener to work to change the whole social system is about as inappropriate as asking a thoracic surgeon why he does not give up the practice of lung surgery and instead work on outlawing cigarettes and certain pollutants in the atmosphere. The answer must be that it is highly appropriate for

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the professional person to engage in social action in his role as a citizen, but to expect him to devote his entire time to such efforts ignores the ethical imperative for using most productively his particular competence in promoting human welfare.

The preliminary report of the APA Committee on Ethics in Research with Human Subjects states: "We began with the commitment that the scientist's distinctive and most effective contribution to human welfare is intelligent application of his scientific knowledge and skills. His underlying ethical imperative, thus, is to carry forward his research as well as he knows how." [5]

In his civic role the citizen-scientist can appropriately work to change the social system or environment that has created some of the problems to which his research addresses itself. In his scientific role, his first concern ethically should be to carry on his research to the best of his ability.

Of class and culture

Another broad issue that comes under general questioning by the public today has to do with the goals and values of the intervener. The issue typically is brought up by members of minority groups or persons who see themselves as spokesmen for minority groups. Many of their questions are highly relevant. The usual accusation is that interveners are promoting a white middle-class model of what is appropriate behavior when dealing with other ethnic groups. Obviously, intervention programs can confound, or can be perceived as confounding, elements of social class and race, for the representation of minority groups—especially the black, the Spanish-speaking, and the American Indian—in the low-income segment of the population is disproportionately high.

Developmental interveners are often accused of working with a theoretical model based on an assumption of deficiency in the subject.[6, 7] In theory we all speak about cultural differences; in practice many of us are concerned with cultural deficiencies. Today these terms are laden with emotion and provoke bitter criticism. In a sense the accusation is just.

There are two ways, however, to look at cultural deficiencies. One is to take the view that a given culture simply tends to be deficient; some cultures are better—presumably in God's eyes—than others. Few social or behavioral scientists would defend such a stand. The other view, a broader one, emphasizes cultural differences among segments of our society but looks at and attempts to remedy the "deficiencies" of a given subculture in relation to a specific societal demand. If we accept the point of view that the technological civilization of the 1970's rewards the person who can read more than the person who cannot read, then we have a case for intervening to correct a specific deficiency—if a person wishes to take advantage of these rewards. Some subcultures have child-rearing practices that make learning to read more of a problem for their children than it is for children generally. Helen Bee has presented a thoughtful analysis of this point of view.[8]

The issue of cultural differences versus cultural deficiencies is, of course, confounded with the failure to distinguish the differences in social class. A few years ago a great deal of professional attention was being directed towards the concept of a "culture of poverty." Those who espouse this concept believe that patterns of coping develop in extreme poverty and that certain of these patterns are institutionalized—that is, they are adaptive to living in poverty but may be maladaptive to moving out of poverty. The

Using a story of a fox stealing chickens, a staff member in the Demonstration and Research Center for Early Education at Peabody College helps a little boy learn to subtract.

late Oscar Lewis [9, 10] was a leading spokesman for this point of view.

Certainly the slum, today often called "the ghetto," is not a new phenomenon. The passing of a predominantly rural society has always brought in its wake the urban slum. One has only to read about the 19th century slums of London in one of Charles Dickens' novels or what Maria Montessori had to say about the slums of Rome early in this century [11] to see that there is nothing new about the debasing of human life in city areas where the poor are congregated.

The confounding of social class differences with true cultural differences has led to problems in planning intervention programs and in observers' interpretations of these programs. How we resolve these problems is probably going to depend in part upon our view of how we should deal with cultural differences.

We could follow the old American philosophy of a melting pot society. Today, however, many minority groups are becoming less and less willing to be melted down. We could ignore cultural differences—a rather unsatisfactory approach since it does not work. We could use cultural differences to build a bridge for meeting the demands of the larger society.

A teacher in an early intervention program shows a mother how to encourage her child to play with educational toys.

This last approach is the one used by many of the more carefully planned intervention programs. The child is taken "where he is." His first reading materials, for example, are based upon experiences that are familiar to him. So far so good; most interveners would "buy" this in relation to certain skills and areas of understanding that are regarded as necessary for a person to have in our ever-contracting globe. The problem is how far interveners should go in this direction.

The more thoughtful intervention programs today, as well as the general trends in our society, seem to reflect a move toward a degree of "cultural pluralism." Ideally, under cultural pluralism many different groups live in the same society with mutual respect, and mobility from group to group is possible not only over an extended period of time but also immediately.

I have found that many of those who cry separatism in this country do not really mean complete separation; when they are pinned down, it turns out that they mean cultural pluralism. Separatists wish to take advantage of the rewards of the larger society, which clearly makes unfair demands on minority groups. But even the separatists do not sentimentalize the life of poverty. It is hard to find anything edifying about cockroaches or ethnically valuable about hunger and disease.

The United States seems to be one of the few countries left in the world where a degree of cultural pluralism is not taken for granted. In few countries, for example, is bilingualism such an issue as it is here. In many countries today it is taken as a matter of course.

Widening options

My suggestion for resolving these issues is certainly not unique, but it is one with which I can live. It is that an appropriate goal in intervention programs is to make possible more options for the individual in his childhood and in adulthood.

One of the most characteristic aspects of poverty is that the poor have no options. The extremely poor must live hand to mouth, day by day, because they are at the mercy of external circumstances; they cannot take advantage of opportunities nor can they plan ahead. In a very different way, certain cultures

tend to restrict individual experiences regardless of socio-economic class. Take, for example, the Amish. In the view of the "old order" Amish, education should be simply teaching the child to read well enough to read the Bible and to cipher well enough to figure simple quantities on the farm. There is some evidence [12] that Amish children experience adjustment problems in school because of the discrepancies between the schools' and their families' values. The way of life of the old order Amish has much to recommend it, but many people would question a view of education that systematically limits the options for the coming generation.

A society that maximizes options may be one having a degree of cultural pluralism but enough commonality in the education of the young to make a range of choices available to all. This approach should not be regarded as based on a belief that the schools and society are always right or that early childhood intervention alone can resolve their problems. Clearly, throughout society, including the schools, many changes are needed to widen the options for young people. The research intervener, however, may appropriately make his scientific contribution by developing knowledge that can be used to improve the ability of young children and their parents to take advantage of these options as they become available or to open up more options themselves.

The American Psychological Association Code of Ethics [13] is currently under revision, with particular attention being paid to a section on research on human subjects. A tentative draft of the introduction to this section,[5] read at the APA meeting last year, dealt with the ethical dilemmas the psychologist faces and suggested as a possible approach a weighing of risk versus benefit. This suggestion should be helpful to those of us who plan to conduct intervention research. But there are difficulties.

As I have already pointed out, intervention research refers to systematic attempts over an extended period of time to make some substantial and lasting changes in the functioning of an immature organism. The nature of the hoped-for changes and the extended period of the intervention make the weighing of risk versus benefit an exceedingly complex judgment, albeit one that must be reached before the research is embarked upon. As the APA report emphasizes, if risk and benefit are in exact balance there is only one ethical decision: to count the risk as more important than the benefit. Unless we can clearly demonstrate that the possibility of benefit from the research is greater than the risk involved, we should not proceed. In the words of the APA report we must maintain "an insistence that the human subject emerge from the experience unharmed and, if possible, with an identifiable personal gain."

Specific principles

Let us look now at some specific ethical principles.

Paramount among these is the importance of remembering that in intervention research *you can't do just one thing*. In attempting to make relatively large and enduring changes in a child and his world, we generally take as the point of entry the child himself, although we may take the mother and child together. However, no matter what the point of entry, when one is trying to make profound changes in a system, one must work with due regard to all the aspects of that system, including the relationships involved. Furthermore, one cannot ethically terminate an intervention program without making whatever provision possible for some type of continuation or sustaining treatment. Herein lies the reason for the increasing emphasis in intervention programs on work with parents and for the establishment of Follow Through programs to pick up in the first grade where Head Start leaves off.

Another principle is the avoidance of the invasion of privacy. This is a particularly tender area for developmental interveners who work with children and their parents in their homes, as we do in our research at Peabody. I have often talked over this issue of privacy with the supervisors of our home visitors. I remember one of them saying that the most important thing for the home visitor to learn is just where the privacy line is, and that this is particularly difficult because the line is different in every home. What one family regards as intrusion may be interpreted simply as friendly interest by another family. A person can easily learn not to pry; it is not so easy to identify the line between intrusion and an appropriate interest in the concerns of the person with whom one is working.

Another problem associated with the invasion of privacy is that work with young children and parents from poverty-stricken homes is good newspaper copy. A nice dilemma is posed when one's long-term goal is to improve the lot of the poor. More public attention to the needs of low-income groups may in time have a positive effect in changing public opinion toward them. But it is difficult to provide public recognition of the needs of the poor without some invasion of privacy, particularly by local news

Encouraged by the warmth of a one-to-one relationship with her teacher, this little girl is learning to count by using an abacus, which was out of the camera's range.

sources. Our solution, not always successful, has been to avoid all publicity until a study has been completed. We have, however, felt an obligation to communicate findings that might be helpful to others, always avoiding the release of any identifying data. It is not always possible, however, to avoid premature publicity. The only solution we have found is to work with reporters of local newspapers and TV stations to try to help them understand why it is important to withhold publicity at a particular time.

Another important ethical principle—one not always honored—is to show respect for the dignity of the individual, whether a little child or an adult. This seems obvious. But persons with a strong middle-class bias are not always able to respect persons whose ways are different from their own. It is not always easy for an inexperienced, middle-class worker to hide an aversion to clutter or to conceal annoyance over complete apathy in the face of a solvable problem. Consequently, a research director must exercise extreme caution in selecting staff members, to be sure that they can show true respect.

A closely related principle is to avoid exploiting research subjects, or even the appearance of exploitation. Whether the exploitation is fancied or real, the feeling of being exploited arouses great resentment among residents of black ghettos and other low-income areas. It goes without saying that genuine exploitation is unethical. What often happens, however, is a result of thoughtlessness—a fascination with a problem causes the researcher to rush in too quickly, without carefully weighing the possible consequences. Spokesmen for minority groups can hardly be blamed if they sometimes feel that behavioral researchers act as though they had discovered a new experimental animal.

Perhaps the best way out of this danger is to take careful counsel with the persons who will be involved in the research. Brewster Smith [1] suggests that with one's "subjects" research workers adopt a genuinely collaborative attitude.

Some difficulties

A well-known ethical principle requires that "informed consent" be obtained from the child's parents and from the child himself if old enough to understand. This principle originated in medical research and is clearly appropriate in medical practice.[14] It may not seem so applicable in nonmedical types of intervention. The possible harm engendered by such intervention is not great compared with possible gains, and the effects are reversible if detected during the program. Still this difference does not save us from risk versus benefit accounting. The developmental intervener, however, has a problem in following the principle of informed consent.

Much of our research is carried on with children who are far too young to understand. The answer, we say, is to inform and get counsel from the parent, by which we usually mean the mother. Well and good, but how can one really inform the parent if the parent has very limited understanding of the principles of child development? Still, one must try to give the parent as great an understanding of the goals and methods of the program as possible. If the principle of informed consent were applied literally, however, most intervention research would have to cease.

My own answer to the dilemma of informed consent is this: intervention researchers should inform the mother as best they can and then should work with her over a period of time to make more options available to her in her interactions with her child. Of greatest importance, perhaps, are efforts to help the mother increase her understanding of and competence in carrying out the acts that will be instrumental in achieving her own goals for the child.

Thus, informed consent in intervention research involves a collaborative approach. It also involves another principle: one must be very careful not to raise false hopes. The best guide is complete honesty with the parent.

Another ethical dilemma facing the developmental intervener derives from the discrepancies in the values between generations. We know next to nothing of the future of the infants with whom we work. Margaret Mead made this excellent point some years ago.[15] Since the future is largely unknown, the major emphasis of an educational program for any human being might well be placed on the development of the qualities and characteristics that make learning possible. Perhaps the only thing we know about life 20 years from now is that the competencies required of people will be different from those required today.

Stable societies, such as the Amish, provide clear illustrations of the dilemma facing today's educational planners. I wonder if those who advocate cultural separatism, or even cultural pluralism, may not have some difficulty with this issue. They may face a question similar to the one raised in the World War I song, "How Ya Gonna Keep 'Em down on the Farm After They've Seen Paree?"

Shall we opt for the current generation of whose values and wishes we have evidence, or shall we opt for the generation of the infants and the small children? To cloud the problem further, major shifts in values are no longer a matter of generations 20 to 30 years apart, but occur even in 5-year spans.

There is, of course, no answer. The legal right is clearly with the parent, but where is the ethical responsibility of the intervener? Perhaps a partial answer lies in our efforts to interpret for the older generation the meaning of rapid change and to try to bring parents along as collaborators in building the kinds of skill and motivation in their children that will allow those children to choose among the opportunities that may be ahead in an unknown future.

Thus, there are only a few guides and many dilemmas in facing the ethical questions involved in developmental intervention. Each person has to make his own judgment as carefully as he can.

Most universities have established the kind of ethics committees advocated by the United States Public Health Service: committees of colleagues to evaluate proposed research plans from the standpoint of the ethical issues involved.[1] Without such a mechanism for outside review, there is danger that the researcher's own bias may sway his judgment.

Unfortunately, however, such committees are seldom able to understand the complexities of the issues involved in a particular mode of developmental intervention. Perhaps what is needed is a kind of collegial review by fellow developmental interveners. Yet in the last anlaysis each person who conducts an intervention study must face the difficult, demanding, and lonely task of determining his own stand on the ethical issues inherent in trying to make lasting changes in young human beings.

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thinking skills as a goal in an after-school program

ROBERT SUNLEY

Every Monday and Thursday afternoon after school 12 first- and second-grade boys and girls in a predominantly black, low-income community in Freeport, N.Y., come to play at the Family Community Center operated by the Family Service Association of Nassau County. At first glance one might have the impression that they are participating in a typical group work program. Despite some noise and confusion, they are presumably learning about taking turns, cooperating, following rules, and listening—somewhat—to the adult leader.

However, more careful observation would indicate that there is a difference. Take the way the children engage in a relay race: Each child in turn runs to a table at the end of the room, pauses to select a button and drop it into one of three cans, and runs back to his team. On the table is an assortment of buttons of three sizes and many colors. The leader calls out, "In the next race, put a small red button in the middle-sized can."

An ordinary relay race has been transformed—to what end? Further observation shows changes in other familiar games and activities—playing tag, making collages and scrapbooks, storytelling, and drawing. The supervisor, Elaine Perkins, explains to the observer, "The children come to have fun. We don't spoil that, but we build in something extra to help them with basic concepts that most of them haven't mastered."

These children, like a great number of others from low-income families in this country, are labeled "disadvantaged" or "culturally deprived." Nearly all suffer some specific cognitive deficits. They lag far behind in the development of "thinking skills"—facility and clarity in visual and auditory discrimination, labeling, comparison and classification, ordering, categorization, and so forth. By the time they start to school, their innate capacities to perform the rudiments of thinking are seriously underdeveloped.[1] They suffer severely as their classmates progress to abstract and complex material. Many lose interest in school, closing their ears and becoming antagonistic. Massive, long-term remedial efforts are then required to reverse such a handicap, even partly.

All the activities these children engage in at the community center are part of a Thinking Skills Program designed to develop and sharpen their cognitive skills. Each fall almost all the children from 5 to 9 in a housing development and surrounding area register for this after-school program; newcomers are accepted throughout the year. The program now has nine groups, each composed of 12 kindergarten, first-, second-, or third-grade children, that meet twice a week. Each group is assigned a Youth Service Project staff member experienced in social work or education and at least one student assistant.

The Thinking Skills Program was conceived by the Family Service Association's Youth Service Project in 1964 as a new element in its group work

for children. Andrew Eklund, then senior caseworker of the Youth Service Project, suggested that a special approach be used with first-grade children in the group work program. He pointed out that there are stages in the process of thinking conceptually that can be utilized in working with a group.

As the staff members formulated the new program, a basic question arose: Shouldn't efforts toward cognitive devlopment be left to the schools as a responsibility logically falling within the province of education rather than within the province of social work?

Two answers affirmed the role of social work:

1. Thinking skills are not necessarily directly related to school curricula; a child needs various nonacademic types of experiences to foster the development of the thinking processes that he will need as an adult to function adequately in a complex urban society.

2. Thinking skills could be incorporated into the agency's group work program already under way. At the time the program began, schools were paying little or no attention to the area of cognitive development. Later, we learned that an evaluation of Head Start type preschool programs showed ". . . conclusively that early compensatory education is of very limited, short-term benefit unless there is consistent followup." [2] The evaluation found that spectacular gains made by children in such programs were quick to erode in the first 4 years of school unless they were constantly reinforced.

The staff envisioned the Thinking Skills Program as a valuable followup of early intervention programs for children with several inherent advantages over school-based efforts:

- The children would come voluntarily for fun; therefore, they would be receptive to the program.
- The children would be associated with others at the same general developmental level, from their neighborhood peer group, thus minimizing feelings of inferiority and failure.
- The development of group cohesiveness and morale would encourage the children to act as motivators and reinforcers instead of relying on the leadership of an adult.
- Programs could be tailored to each small group, with no need to become standardized.

The practical application of the thinking skills idea was difficult. While confronted with the day-to-day problems of conducting a group program for children, the leaders had to experiment with new methods and attitudes. The program director and the supervisor had to grope their way among theories while trying to give specific direction to the leaders.

To date, the Thinking Skills Program has served more than 200 children. Its concepts have been adapted for use with groups of older children and in the Association's summer day camp.

Program emphases

Seven major aspects of learning theory have been taken into account in the program. The following paragraphs describe the theoretical background and how it has been translated into activities.

Sequence and transferability. The literature on learning emphasizes the importance of introducing planned experiences to children in a logical sequence and of proceeding in very gradual steps.[3, 4] The requirements for learning would not be met if children were exposed to many essentially unrelated experiences of various levels of complexity.

Transferability refers to the ability to adapt a concept that is applicable in one context to other somewhat different contexts. For example, a child learning the concept of *relative sizes* must be able to transfer a comparison of three cubes to a comparison of three different kinds of animals to a comparison of remembered objects. Children master transferability and other mental capabilities at different rates; their abilities do not develop in a straightforward logical progression as adults tend to assume.[5]

In the Thinking Skills Program, the importance of sequential learning is taken into account by providing connections between activities within a session and from session to session. Sometimes a related

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Boys in the Thinking Skills Program learn about time by making clocks and reviewing sequential pictures with one of the program's group leaders.

theme or area of interest is sustained through many sessions. Leaders adjust the sequence of individual activities, the emphasis on transferability, and the small transitional steps in concept development largely through trial and error. After observing the times that children show uncertainty, vagueness, or achievement, the leaders review the structure of a game or other activity to simplify it or to introduce additional steps.

Transferability is emphasized by eliciting an idea from the children, by pointing out other applications of it in their daily lives, and by reviewing the steps they took to arrive at their conclusions. A leader may gradually increase the complexity of a relay race, for example, to give the children practice in discriminating between essential and extraneous elements.

Language development. Language plays a highly important role in a child's cognitive development, although its exact relationship has not been established.[6, 7] The ability to communicate in oral and written language is an invaluable asset in school as well as in adult life. In the Thinking Skills Program, emphasis has been placed on sharpening the child's ability to receive and understand communications from others and to express himself verbally.

The leaders follow a staff-written guide that relates various aspects of the English language to the concepts emphasized in the program. For example, the guide points out that the general concept of *classification* (involving comparison) is embodied in the selection of nouns that go together, and that sequence of events is expressed through verb tenses and qualifying adverbs and clauses. In teaching the concept of *before and after* to disadvantaged children, the leaders make use of the time sequences that arise in a child's spontaneous telling about what happened on trips or at home. The development of the concept of *we* is fostered through games of identification, such as the one in which children call out the names of group members.

Correlation of motor activity with early steps in cognitive development. A child makes a very gradual transition from merely handling an object, to developing language and mental images as he handles it, to developing mental images that do not depend on the presence of the object. The motoric accompaniment appears to be necessary until cognitive development is fairly far advanced.[6] In most thinking skills sessions, motor activity is built into games, arts, crafts, and other play. The leaders encourage the children to talk about their physical activities and so take the mental steps necessary for cognitive development. For example, in the relay race the child may progress from selecting a button to telling another child how to select the "right" button. As he reviews the activity involved in selection, he is taking a step toward symbolic thinking.

The program emphasizes objects familiar to the child in his daily environment. It introduces new experiences gradually, limiting the variety of stimuli to those the child may be able to absorb at one time. By preparing the child to apply what he has learned within his own environment, the learning experience is likely to become reinforced through frequent application.

Activities without failure. The child with a cognitive handicap is particularly vulnerable in situations where there is a clear-cut standard of success and failure.[8] Therefore, to counteract the disadvantaged child's already existing feeling of inadequacy, the program avoids individual competitions, group activities in which many children fail, and other activities that inevitably favor the same few

children who know the "right" answer. Instead, the leaders ask individual children questions tailored to the child's specific experiences, and select games that emphasize intergroup competitions.

Developmental level. Initial assessments of the level of conceptual development of each child and of the group as a whole provide a basis for gearing the program to the children's needs. In part, these assessments are made through simple tests in which children respond to questions of reasoning—such as dividing a list of items into categories of "same" or "different." In part, each group leader uses program activities to discern the children's developmental level.

The children in each group represent a fairly wide range of development. At the end of the first year the staff found that the Thinking Skills Program had helped children who initially rated high in conceptual development, but it had had little impact on the children who rated low. In the second year when the emphasis of the program was shifted to simple comparisons, children with initially low ratings made definite gains.

Structure of participation. Many types of activities are used to achieve program balance, including both active and quiet games and other activities that permit individual participation or expression by the children. Some games involve taking turns, one at a time; some involve taking turns in pairs; some are "all at once" games; some involve eliminations. Games that require long waits for most of the children have been eliminated, however, because such games not only foster inattention and misbehavior but also severely limit the amount of time any one child gets to practice the conceptual tasks involved.

Arts and crafts provide opportunities for individual expression and trips introduce new experiences. The variety is compatible with attempts to make the program fun, thus distinguishing it from school-type programs that tend to be repetitive, sedentary, and nonparticipatory.

Group behavior. The aims of any group program can be negated by inattention and disruptive behavior. The Thinking Skills Program leaders have followed two models in handling disruptive group behavior. The therapeutic model calls for the development of a positive relationship between the leader and each child, and for discussions of the feelings behind the child's behavior. The behaviorist model uses both positive and negative reinforcements. For example, the leader initially may ask the children to sit quietly at the table; he serves snacks only after they have followed his directions. He continues to work with the group members until they do not need a reward to sit still for a long discussion.

To understand the children's behavior, the leaders use assistants' observations of individual children, as well as knowledge of each child's home situation in relation to its possible effects on his behavior from week to week.

When, for example, James, age 7, came in to the center one afternoon with a sullen expression, the assistant alerted the leader for trouble. Soon it began. James teased and wrestled with the other children, but would not talk to the adults. Later, the leader visited James' home and learned that his mother had been rushed to the hospital. In the next session James was encouraged to talk about his anxieties instead of acting them out.

Leaders also try to develop a favorable group attitude toward the development of cognitive skills. This emphasis is particularly important in low-income areas, where children's peer groups seem more influential than parents or school.

Planning and implementation

In the first year, plans for group activities were drawn up by the leaders, reviewed by the supervisor and director, and then followed fairly consistently. This method proved to be too rigid. Therefore, in the second year, the leaders were given more latitude in selecting activities within a planned sequence of sessions that maintained an emphasis on the concept of *size*. But again, the planning provided too rigid. Since then, the agency has developed a repertoire of successful activities from which the leaders can make selections for a balanced program. Furthermore, such a repertoire gives a leader the flexibility to modify a plan on the spot, if necessary.

The following brief descriptions of specific program activities show how games have been modified to accentuate the ideas being emphasized.

A planned series. A series of eight sessions was projected near the beginning of the year to teach a group of first graders several new concepts. At the first session the children played color basket upset, a modification of fruit basket upset that uses colors as well as names of fruits. Session II introduced the concepts of *big* and *little* in the game. A relay

race was also staged at this session, with the children divided into teams; the emphasis was on rules and structure since relay racing was new to most of the children. The fourth session introduced the concept of *middle size* into the fruit basket upset game and the selection between two colored objects into the relay race.

The relay race was repeated in later sessions and a third object was added, giving the children a choice between big, middle-sized, and small objects. In all the sessions the leaders used picture books, such as "Let's Find Out What's Big and What's Small" and "The Three Bears."

These sessions were moderately successful. Some leaders said, however, that changes were introduced too rapidly and that most of the children needed more repetition of the concept of *middle size* earlier in the series.

Group identity. The use of a picture puzzle that included the name of each child in the group helped in building a sense of group identity—that is, in developing a sense of "we" in relation to "I"—and in setting a tone of purposiveness for the group activities. One of the puzzles, for example, took the form of a clown with a child's name written on each piece. One leader has described how she used this activity:

> **Then I brought them over to the new puzzle. William grabbed his piece at once and began to look for its corresponding shape. He couldn't find it. Then James found it for him. I asked the others to find their pieces and they did. Each of them worked with the others to find the place for the piece. I did not interfere. When four pieces were in, I asked if they knew from looking at the partly finished puzzle what it would be. Tommy said a clown.**
>
> **We went from piece to piece, calling out the person's name and then finding the right spot for the piece. With each name I asked if the child had been seen today, and we found out this way who was absent. Then we looked at the finished product and Susan said Tommy had guessed right.**

Color tag. One leader devised the game of color tag because many of the first graders did not know the names of colors. He taped colored squares of paper to the floor of the meeting room and all the children except the one who was "it" had to stand on a designated color to be "safe." The game progressed to the use of two different colors for "safe," with the children naming the colors for each new game

Orientation of the agency's staff to the Thinking Skills Program has been conducted through seminars. By helping give tests to the children before and after participation in a group, the group leaders discovered for themselves some of the children's deficiencies. The leaders receive continuing supervision, part of which is focused on the problems of individual children. They also make occasional home visits.

Evaluations of the program have been made each year, although the focus of the Youth Services Project has necessarily been on service rather than research. In the second year, children were assigned to either an experimental group or a comparison group. Each group had the same number of children who made high, medium, and low scores. Throughout the year, the children in the comparison group participated in a regular group work program that did not emphasize thinking skills. The results of the post-tests indicated that the experimental group showed statistically significant gains over the comparison group. In the following years ratings by leaders and public school teachers and other methods of evaluation have indicated that the program has definitely helped the children, although it has not succeeded in eradicating their cognitive handicaps.

The emphasis on thinking skills has applicability in many other group programs for children—in settlement houses, neighborhood centers, day camps, and other settings. The program does not require either special equipment or costly materials. Groups can be led by paraprofessional or professionally trained social workers. Staff orientation and continuing supervision are necessary, however, for an effective program.

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SOME THOUGHTS ON PLANNING HEALTH CARE FOR CHILDREN AND YOUTH

HELEN M. WALLACE

High among the priorities for action recommended by both the 1970 White House Conference on Children[1] and the Joint Commission on the Mental Health for Children[2] is a nationwide network of comprehensive health services for children and young people. Comprehensive health services to provide children with "care and treatment through facilities which are appropriate to their needs" are necessary, according to the Joint Commission, to assure children's rights: to be wanted, to be born healthy, to live in a healthy environment, to satisfy basic needs, to have continuous loving care, and to acquire the ability to cope effectively in our society. Such services, in short, take a broad view of the whole child in his environment and are concerned as much with prevention of ill health as they are with effective early treatment.

In recommending a national program of comprehensive health services, one of the White House Conference forums on health stressed the necessity not only of developing new delivery systems but also of building on our existing strengths.[3] What then are these strengths and how far do they go toward meeting the need?

Aside from the few private ventures in prepaid group medical practice, some union health plans, and an unknown number of centers for handicapped children, most of the experiments in the delivery of comprehensive services for children have probably been developed under the stimulus of Federal aid or direct Federal support, the most comprehensive of them within the past decade. They include the 59 children and youth (C and Y) projects, through which health departments, teaching hospitals, or universities provide medical, dental, social, and other services for children in defined low-income areas on a continuing basis from birth to age 19;[4,5] the 53 maternity and infant care (M and I) projects for high risk mothers and infants up to the age of 1 year; the 54 State crippled children's services; the 21 university-affiliated centers and 200 community clinics for mentally retarded children; the health components of 1,600 Head Start programs for preschool children;[6] and the 55 neighborhood health centers operated by community action programs in low-income areas.

In spite of this variety of programs, comprehensive health services are the exception rather than the rule. None of these Federally aided programs reaches more than a small fraction of the children in the category for which they were intended. There are, for example, about 80,500,000 children and young people under 21 in the United States, about 16,100,000 of whom live in low-income areas. Of these, only about 1½ million were registered in 1970 with one of the Federally aided services providing comprehensive care: 434,300

A physician with a young patient and her mother at a pediatric center in a low-income area of Baltimore established to provide comprehensive health care to children and youth.

with C and Y projects; 45,000 with M and I projects; 450,000 with State crippled children's services; 5,250 with university-affiliated centers for the mentally retarded; 53,000 with community clinics for the mentally retarded; 471,600 with Head Start (262,900 in full year programs and 208,700 in summer programs); and 180,000 with neighborhood health centers.

Little is known about the kind of health care the 14,500,000 other children from families of low or marginal income receive. Many thousands, of course, receive medical care from private physicians or hospital outpatient or emergency clinics, much of it paid for by the Federal-State program of Medicaid. But it is not a mere guess to suggest that most children of low-income families—and many others too—receive only episodic care, with none of the preventive and followup services implied in comprehensive care.

Clearly, comprehensive planning is needed to assure that all children and youth will have easy access to comprehensive health care. Two possibilities suggest alternative ways for bringing this about: (1) the revision of Federal legislation and provision of funds to allow extension of the present maternity and infant care projects, children and youth projects, special services and centers for handicapped children, neighborhood health centers, Head Start health services, and perhaps, the services to be established under the new Health Start program (see p. 112); and (2) a clearer identification of the effective components of these and other group practice programs, which should then be applied, through coordinated planning or one direct service, to all children and youth or, at least, to all who are indigent or medically indigent or who have serious health problems.

Extending coverage to all children or to all children needing it would require eliminating restrictions on services based on geographic boundaries within a community. Rather, planning would provide for a network of interrelated services covering the entire community through a system of district services linked to a chain of neighborhood services.

At the neighborhood level, physicians in private practice would be invited to participate in the organized comprehensive health care programs. This could be done—and already has been done in some children and youth projects—by offering physicians who are practicing in low-income areas private office space or part-time or full-time positions and inviting them to participate in the service's staff conferences, reviews of the needs of individual families, inservice training programs for staff, and other educational activities. In any event, there needs to be a better tie-in between physicians in private practice and community services. And all physicians serving children need to have a hospital affiliation.

There also needs to be a better tie-in between State crippled children's services and local community planning for handicapped children—especially in large cities—in the interest of better case-finding, followup, and provision of social and recreational services.

To insure both quality and accessibility, comprehensive services are usually conceived of as involving three levels of health care: *primary care* at the point of entry; *intermediate care* for seriously ill children; and *advanced specialty care* for children with complicated problems.

These characteristics of comprehensiveness are provided for by C and Y projects in various ways. For example, in one large city, where service coverage has been broadened through the combined efforts of the local health department and the two C and Y projects in the community, the three interrelated levels of care include:

Level one, consisting of the health department's neighborhood well-child conferences greatly improved by the provision of closer pediatric supervision; the addition of social workers, nutritionists, and health educators; the provision of basic laboratory diagnostic services; the addition of a program of screening infants and young children for communi-

cation problems; and the addition of treatment services for minor illnesses.

Level two, consisting of the seven C and Y satellite centers, with a total registration of 50,000 children, staffed to provide more sophisticated diagnostic and treatment services for ambulatory patients. Each of these centers is tied to a medical school or teaching hospital, which provides the key medical staff and in-hospital care when needed, and each serves as the place of referral for infants and children from several well-child conferences.

Level three, consisting of the participating medical schools and some teaching hospitals, includes the provision of highly sophisticated diagnostic and treatment services for children referred from the satellite centers.

Thus, by this agreement, existing health services are being improved; intermediate services of a more comprehensive nature are located close to the people who are to be served; the most highly developed services with the most highly skilled personnel are reserved for children and adolescents with special problems; and more children and adolescents are being provided with preventive, diagnostic, and treatment care of improved quality.

Financing and costs

As of December 31, 1970, children and youth projects were caring for 434,300 children and young people a year, at an annual estimated cost of $60,897,546 (representing both the Federal and matching shares), or an average of $140.22 per child per year—an average within the range of $100 to $200 usually estimated as needed for medical and dental care of a child per year.[7] Projections based on the annual reduction in hospital care per child in this program will reduce this average to $129.80 by June 30, 1971.[8]

Applying the projected average C and Y expenditure of $129.80 per child per year, the annual cost of providing comprehensive health care to all 80,500,000 children and youth in the United States would amount to approximately $10.5 billion or 172 times the total present funding of the C and Y program.

According to estimates for 1967, total annual expenditures from all sources for the health care of children under 15 years of age amounted that year to $6 billion, three-fifths the estimated cost of providing comprehensive care to all children and youth as based on the C and Y projections. Of these 1967 expenditures, one-tenth came from the Federal government, two-tenths from State and local governments, and the other seven-tenths from insurance benefits and direct payments from families.[9]

Even limiting the provision of comprehensive health care to the 16,100,000 children and youth in families classified as medically indigent, the annual cost of providing comprehensive health care at $129.80 per child per year would be nearly $2 billion if all such children were included and would require over 33 times the present level of Federal, State, and local funds for the C and Y program.

By far the largest and most rapidly growing proportion of Federal expenditures for health care of children comes through the public welfare program, Medicaid, which channels funds for payment predominantly into private physicians' offices. Furthermore, the seven-tenths of all annual expenditures for health care of children that comes from private sources also are predominantly made to private physicians. How much planning for preventive care, auxiliary services, and followup attention is involved in such expenditures is unknown.

From the viewpoint of paying for comprehensive care several steps are open, which may be taken in concert or as alternatives:

1. The appropriation of additional funds for the comprehensive health care of children and youth.

2. Decreasing the annual cost per child for comprehensive health care for children and youth. Experience has shown a steady decline in the costs of C and Y projects the longer the children are in them, presumably because of the effectiveness of preventive care.

3. Diverting funds used to pay for episodic health care of children and adolescents to programs providing for comprehensive care.

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In any event, funds will have to be drawn from all existing sources—government at all levels, voluntary insurance programs, and payments from individuals. Or, at least, funds from all available sources will be needed until comprehensive health care for all children and youth is provided for through a national health insurance program.

Current C and Y projects

The University of Minnesota Systems Development Project, established for the continuing evaluation of C and Y projects, recently analyzed the patterns of delivering care in such projects according to the geographic and administrative location of their base.[10] Some interesting differences were revealed.

Of the 58 C and Y projects analyzed, 19 were administered by medical schools, 22 by other teaching hospitals, and 17 by health departments. Forty-three of the 58 projects were located in central cities, nine in peripheral urban areas, and six in rural areas.

As was expected, the projects planned and administered by health departments had close working relationships with schools, welfare agencies, and visiting nurse services because of their past affiliation with such organizations. Four of the six projects serving rural areas were administered by health departments, which are more likely to be available in rural areas than teaching hospitals or medical schools. Other advantages of locating comprehensive care programs in health departments, affirmed by the study, are the possibility of influencing existing health services and integrating them into the program and the greater likelihood of outreach for case-finding and followup of children in need of service.

The analysis showed that where C and Y projects are administered by medical schools or teaching hospitals, children already known to the operating institution are frequently referred for care. In these projects, children are more often hospitalized; this might mean that the children in these projects are more likely to have a serious or potentially serious condition, or it might mean that there is some unnecessary hospitalization of children.

C and Y projects based in medical schools or teaching hospitals would be expected to find it easier to provide medical and dental care than health departments, although dental care is less easily available than medical care. However, the study showed that C and Y projects based in teaching hospitals had a higher percentage of children "registered only"—that is, awaiting assessment—than either of the other two types of projects. Only in regard to dental care were the teaching hospitals apparently able to deliver care more expeditiously than health departments. However, projects in medical schools reached and served more children in their target areas than the teaching hospitals.

Some advantages of basing a C and Y project in a teaching hospital or medical school, not mentioned in the analysis, are that it may make a higher quality of medical care available, it is more likely to be used for teaching purposes, and it is more likely to conduct research.

Under any auspices, a comprehensive health care program for children and youth has the following responsibilities:

- Providing extensive coverage for children in its target areas.
- Reaching out to promote and accept referrals from community agencies; working with them to keep them informed; and utilizing their resources, skills, and followup services.
- Accepting children immediately for examination and care without a waiting period.
- Providing preventive, diagnostic, treatment, and rehabilitative services for all children in the family.
- Providing hospitalization, but keeping it to the necessary minimum.
- Making the service easily available for training medical, paramedical, public health, and allied health personnel.
- Conducting research to determine the relative effectiveness of various methods of delivering services in improving the health of children.

Total family care

In the future, comprehensive care of children and youth in one form or another will need to be an integral part of comprehensive care for all family members, or at least much more closely linked to total family care than at present.

One example of presently fragmented services is the lack of coordinated planning and administration between the 53 maternity and infant care projects and the 59 children and youth projects. Only 19 communities have both an M and I and C and Y project. More communities would have had both types of

projects if the expanded funding anticipated for these programs a few years ago had been forthcoming. However, at present in only about one-third of the communities with M and I projects can all families and all family members receiving care under M and I immediately and automatically graduate to C and Y.

To be truly comprehensive, the delivery of health care ought to be so organized that any woman of childbearing age receiving any type of medical and health care for herself would also have all of her children and her husband cared for, and any child receiving care would also have his siblings and his parents cared for. Maternal care, family planning, and abortion counseling and service would be linked to child health services as would specialized services for adolescents. Well-child conferences would no longer be confined to preventive and counseling services, but, as outposts in a comprehensive program, would increase their casefinding efforts and would provide treatment for some illnesses. Schools would be integrated into the program with improved casefinding, health education, counseling, referral, and followup services. Head Start programs, day-care centers, nursery schools, and parent and child centers, closely linked together to provide an enriched program of social, recreational, play, and educational experiences for infants and preschool children, would also be integrated into the health care delivery system.

Many families may put lower priority on their health needs than on other immediate and basic needs—housing, food, clothing, jobs, legal advice. Thus, the planning for comprehensive health care ought to be a part of planning for a total spectrum of services including—in addition to programs to meet these basic needs—programs to provide education for preschool and schoolage children, day care for children, guidance and vocational assistance to youth, services to neglected, abused, and emotionally disturbed children, comprehensive services to teenage pregnant girls, counseling and treatment of teenage drug users, family planning and abortion services, family life and sex education, and services to prevent and control delinquency and venereal disease.

At this point, a word of caution is pertinent. In the rush to provide a system of integrated comprehensive health care for all children, all parents, and everyone else, steps must be taken to safeguard the quality of care. For example, standards of patient care should be established by experts; qualifications for staff should be established and adhered to; preservice and in-service training programs should be continuously carried on; consultant services to provide certain specialized knowledge and skills should be available; supervision of personnel should be continuous. Research on the effectiveness of methods of evaluation and care should be carried out.

Innovative programs in the delivery of health care, such as the C and Y projects and the neighborhood health centers, have an opportunity to experiment with methods of health evaluation. The availability of a multidisciplinary team, of continuity of care, and of a close family-staff relationship—characteristic of these programs—make such experimentation possible. Information is needed on the reliability of certain types of medical tests, the productivity of such tests, their costs, and their specificity. The Pediatric Multiphasic Program at Kaiser Hospital, San Francisco, is currently using a battery of 17 tests to obtain such information.[11]

Other studies greatly needed are:

- Studies of the health status of children and adolescents from low-income families, and also of their parents, to determine the health needs of this group of the population.
- Comparative studies of the cost and effectiveness of various methods of delivering health care.
- Comparative studies of various methods of casefinding.
- Studies monitoring patient care, to determine the end results for the child and his family.
- Studies of recipients' opinions, reactions, and suggestions regarding their health care.

Manpower needs and use

A major problem is the availability and use of health manpower. If current projections are correct, the 1970's will see some reduction in the serious shortage of physicians, but a substantial increase in shortage of dentists, nurses, and allied health manpower.

As important as the question of numbers of persons available to work in the health field is the question of how they are used. Numerous reports have been published on the use by pediatricians in private practice of persons in allied health fields. For example, a nationwide study [12] recently found that many pediatricians employ registered nurses to perform clinical, laboratory, technical, and clerical tasks. Tasks classified as "patient care" were less

frequently delegated by physicians than technical or clerical tasks. What tasks and how many were delegated was, of course, influenced by the number and qualifications of health workers employed.

The study indicated that the patient-care tasks most frequently delegated to nurses by pediatricians were the acceptance of telephone calls — the most urgent and least controllable pressure in practice— and tasks described as the most easily "routinized," such as initial history-taking and giving instructions to the patient. The tasks least frequently delegated were those involving clinical judgment in a close patient relationship, such as making physical examinations and taking interval histories.

Many of the respondents indicated that they would be willing to delegate more patient-care tasks if trained allied health workers were available.

Other studies have reported favorable responses by parents to the use of registered nurses as pediatric nurse practitioners or as pediatric assistants.[13, 14] The Chicago Head Start program has used pediatric nurse practitioners to perform physical examinations for screening purposes and has found their performance satisfactory.[15]

Except in the use of nonprofessional aides and dental assistants, few analyses have been made of patient care in relation to the roles of various professional and nonprofessional health workers. Innovative programs, such as C and Y projects, neighborhood health centers, and Head Start health programs could lead in experimenting in this direction with a view of determining the most efficient use of health workers of various types.

Information about innovative approaches to health care ought to be disseminated as quickly as possible so that such approaches can be used in the training of medical, paramedical, and nonprofessional health personnel at all levels of their education—undergraduate, internship, residency, postgraduate, and field placement and observation. The training should be concerned with individual and family care and also with the administrative aspects of providing service, including planning, operation, and evaluation.

Health personnel undergoing post-graduate training in schools of public health especially need exposure to the new approaches to health care, as they are likely to be key planners of future efforts to improve the system of providing health care for the Nation's children. However, continuing education of all types of health workers involved in the care of children is essential.

Ideally, comprehensive health care of children and youth provides preventive, curative, and rehabilitative care on a continuing basis.[4] It begins prior to conception and continues throughout infancy, childhood, and adolescence. It includes the medical, dental, social, emotional, educational, vocational, recreational, nutritional, housing, and environmental aspects, as well as day care, homemaking, baby sitting, and transportation. It is interdisciplinary. It is coordinated by providing for quick referral of the child and his parents to whatever service is needed and for interchange of information between the services. It is easily accessible and available, 24 hours a day, 7 days a week. It provides for careful health and social appraisal of each child and the members of his family. It provides methods to safeguard the quality of care. It incorporates continuous planning to assess resources, define goals, determine unmet needs, establish priorities, and provide the indicated care. It includes participation by both the providers and the consumers of health services in the decisionmaking process.

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RESEARCH for SERVICE to Severely Retarded Children

IRENE L. ARNOLD • STANLEY BUDNER

Most social agencies are faced with demands greater than their financial resources. Because of this fact, there are those who deplore the use of every penny not spent on direct service. We would submit, however, that in such a situation research is a must to help the agency use its limited funds in the most effective way possible.

Experience at the Retarded Infants Services (RIS) in New York City provides an example of the use of research as a tool of service in a small voluntary agency with very limited resources. RIS deals with problems involved in the care and treatment of severely retarded children and their parents. Once concerned almost exclusively with children under 5, it now also serves severely retarded older children. The agency provides information and referral services; pyschiatric and psychological consultation; home aides to help families care for their retarded children; parent counseling, individually and in groups; and supervision of a parents' visiting service to parents of mentally deficient newborns. In addition, RIS also undertakes special projects: home care to high-risk pregnant mothers, early casefinding in areas of poverty, and the training of home aides.

Thus, the primary focus of Retarded Infants Services is service. Research is secondary. But why does the agency divert any of its resources away from its helping efforts? The answer lies in the very shortage of money for service.

First, because its resources *are* limited, RIS believes that it has a responsibility to learn how to make the most forceful impact it can with what it has. It assumes that it can serve more people better and more efficiently if it knows how to look for better ways of providing service. And research is its way of looking.

Second, because RIS has focused its efforts on a relatively neglected part of the population, the severely retarded child in the community, it has been compelled to innovate viable programs where no programs have existed. While innovation requires imagination only, viability requires knowledge.

Given the realities of its service orientation and shortage of funds, RIS must confine its research to studies that can show concrete results: acquiring information to be used in developing new programs; providing feedback on the strengths and weaknesses of existing programs; and evaluating both old and new programs so that appropriate decisions can be made as to which should be scrapped, which modified, and which expanded. Research into more basic questions must, unfortunately, be left to others or to that hoped-for day when the agency's budget is a source of comfort rather than stress.

Given this rationale, Retarded Infants Services has in the past decade carried out studies on the following subjects:

1. The value of homemaker service in the family with a retarded child under five.

2. The feasibility of training unskilled personnel to assist professional staff in the care and treatment of mentally retarded children.

3. A survey to evaluate and identify the unmet needs of severely retarded children living at home.

4. The best method to recruit foster home care for mentally retarded children.

5. The incidence of early identification in 14 selected hospitals in New York City.

6. A client evaluation of the agency's services.

7. A comparison of mothers who place their children at birth and those who keep them at home.

Based on a paper presented at the annual convention of the American Association on Mental Deficiency, Washington, D.C., May 1970.

The first two studies received support from the Children's Bureau, the third and fourth from the New York State Department of Mental Hygiene, and the fifth from the New York Community Trust. Studies six and seven were supported by the agency's own budget.

How can these studies contribute to development, feedback, and evaluation of the agency's services? The results of some of them have already been reported [1-3]; others are still in process. We will here give examples of the purposes of some of these. However, we will discuss in more detail our recently completed study, "The Survey of Unmet Needs of Severely Retarded Children Living at Home."

Two of the studies, the "Value of Homemaker Service" and the "Feasibility of Training Personnel to Assist Professional Staff," illustrate both the feedback and evaluation function of research. In undertaking the homemaker study, we had no doubt that parents of a severely retarded young child would welcome the extra pair of hands provided by a home aide. But how far would parents go in accepting a broader role for the aide? Would they accept the home aide as someone who had useful knowledge for dealing with a retarded child and who was qualified to train parents to care for such a child? In addition, the agency needed to know what problems characteristically arise in a family with a retarded child so that the home aide could be prepared to deal with them. Finally, it needed to know whether the women who served as home aides could be prepared to deal with retarded children and to train their parents to do so.

In the second study, the feedback role of the research was critical. The agency trained three successive groups of lay people to serve as assistants to professional staff. If the experience with each group was to be used to improve the program, some reliable means had to be developed for monitoring the program, including the procedure used to select trainees, the training itself, and the placement procedure. Further, if the report of the study were to show more than simply acceptance or rejection of the assistants, we needed to understand the factors determining the acceptance or rejection.

Another study (number 7), now being prepared for publication, deals with a major question that continues to be unresolved in the field of mental retardation: when should a child be institutionalized and when should he be kept at home? This is particularly a problem for RIS because of its emphasis on severely or profoundly retarded newborns and infants. The question of whether or not to put the child in an institution is one that sooner or later the agency is forced to deal with by its clients.

What does one tell or advise the parents when the question is raised? The degree of severity of the retardation is certainly critical, but it is not by itself a sufficient determinant of the nature of the advice. What the parents' decision should be depends on many other factors in the situation—social and economic status, the quality of their marital relationship, the effects of the retarded child's presence on other children in the family, the mother's mental health and her motivations for placing or keeping her child. To begin developing guidelines for RIS staff members in this sensitive area, the agency carried out this study of the psychological motivations influencing the decisions of mothers of neonates afflicted by Down's syndrome (mongolism).

The three studies just described are "product" oriented—that is, they are concerned with what the agency ought to offer families with severely retarded children. But it is also important to look at the "marketing side" of an agency's activities. How do the families that have come into contact with RIS perceive the agency? To answer this question, all parents seen by the staff in a 3-month period in 1966 were sent a questionnaire a year after their initial contact. Many of the parents' comments on the returns helped pinpoint what are probably common disjunctions between client needs and the administrative structures and policies of social agencies. From a service perspective, perhaps the most interesting finding was the prevalence among the parents of the feeling that they had been unable to articulate their needs and that RIS should not have taken "no" for an answer when its offer of a particular service was refused. In other words, when a client of a social agency is under severe stress, a passive acquiescence to the client's right of self-determination may not be what the client needs or wants.

Unmet needs

An example of the use of research as a basis for program development is provided by the recently completed study, "A Survey to Evaluate and Identify the Unmet Needs of Severely Retarded Children Living at Home." This study was designed as a corollary of one carried out by the New York State Department of Mental Hygiene: "Appropriateness of the Continued Institutionalization of the State School Population in New York State." Because RIS pri-

marily serves families with severely retarded children, the Department chose it as the appropriate agency for studying the needs of families keeping retarded children at home although institutionalization had been recommended for them because of the severity of their retardation.

The data collected in the course of the study are detailed and complex. They touch on such questions as the social, familial, and psychological factors affecting the decision to maintain a severely or profoundly retarded child at home as well as on the consequences of this decision. Here we will discuss only the problems and needs of families that have made such a choice as these have been reported by the parents.

The study sample consisted of families with a child who—

1. Had a general IQ level below 30.

2. Was between 2 and 16 years of age. (The lower age limit was set to eliminate two types of situations: those in which a child was home because of the common 2-year delay between application and institutionalization; and those in which a decision to keep a child at home was almost immediately changed.)

3. Was at home within the primary family unit despite a recommendation for institutionalization.

Records from four agencies were used: RIS; Mental Retardation Center, New York Medical College and Flower Fifth Avenue Hospital; Children's Developmental Evaluation and Rehabilitation Clinic of the Albert Einstein College of Medicine, Yeshiva University; and the Association for the Help of Retarded Children. Altogether 67 families that met the criteria were identified. Of those, 27 were not contacted, because they lived outside of New York City or could not be located. Of the 40 families contacted, 37 agreed to be interviewed.

In 19 of the 37 families, both the husband and wife were interviewed; in 18, the wife only. Data were collected through the use of a semi-structured schedule that asked about the basis for the decision to keep the retarded child at home, the child's needs and problems, the effect on the family of the child's presence in the home, and the family's use of social services.

The families were predominantly white, Catholic, or Jewish, with varying but stable incomes. The retarded children ranged in age from 4 to 18; the median age was about 8. Nineteen of the children were boys; 18, girls. At the time of the interview, 27 of these children were still at home, eight were living in institutions, and two had died.

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The records showed that of the 37 retarded children, 25 had been considered untestable for an IQ score. Half had been diagnosed as having severe brain damage, one-fourth as having Down's syndrome. All of the children suffered in varying degrees from handicaps related to their retardation—convulsions, seizures, multiple anomalies, epilepsy, and so forth. Furthermore, the level of self-care achieved by the children at the time of the interview was extremely low—30 were completely dependent on others for washing and bathing, 26 for dressing, 23 for toileting, and 15 for eating. By any definition, these children were severely retarded.

With respect to problems encountered in learning about their child's condition, the parents were first asked when the initial diagnosis was made. Despite the severity of the children's retardation, the parents of 14 children, or almost half the study sample, reported that their child's condition had not been diagnosed until the child was more than a year old; four of these children had not been diagnosed until they were more than 2 years old.

The parents were also asked to recall what they were told at the time of diagnosis. Only eight reported having been given more than just the medical diagnosis: of these, three had been given a recommendation to place the child in an institution; two, hope for possible improvement; and three, a very general prognosis, such as "she will develop slower than others in her age group." The rest were left hanging.

When asked about the information or help they would have liked to receive, the parents emphasized practical information: being told what a severely or profoundly retarded child is really like and where they could go for help. In fact, throughout the interviews, the parents had a continuous refrain: "Had I but known what it really meant!"

A picture of the effects of maintaining the retarded child at home was obtained through the parents' responses to a number of open-ended questions. Five recurring themes emerged:

1. The need for help with the problems of learning how to deal with the child, how to train and discipline him, and how to cope with the unremitting strain of caring for him day in and day out.

2. The constriction of the parents' social life. Few of the parents ever go out of the home for recreation, entertainment, or visiting with friends. Many do not even entertain in their homes. For the majority, social life consists of visits by and to other members of their families. Those for whom this is the preferred life style appeared to be the most satisfied with the decision to keep their child at home.

3. The inability to take a family on vacation away from home. Many of the mothers were concerned about the effects of this constraint on their husbands and the other children.

4. The inability to give appropriate attention to other children in the family because of the demands of caring for the retarded child.

5. The economic burden imposed on the family by the child's condition—bringing high medical expenses and at the same time preventing the mother from working to increase the family's income.

To learn about the relations of these families to social agencies, the investigators asked the parents to list all the agencies they had thought of approaching for help. They had thought of and approached many. Twenty of the families, for example, had gone to four or more agencies. And, in nearly all instances, they had received some service from the agencies they approached.

The parents were also asked about the sources of their knowledge about the agencies, whether formal (professional) or informal (family and friends). Ten specified formal sources only; seven, informal sources only; and 17, a combination of formal and informal sources. In this last group, the informal source tended to be the launch point to service, a personal referral to an agency that then passed the family on to another community resource.

Finally, the parents were asked about problems they had had with agencies. Three-fourths reported some kind of problem, the most frequently mentioned being delays in getting service (13), difficulties in dealing with staff members (10), and needs not met (8). It is our impression that the parents' difficulties with staff members frequently revolved around a conflict between the parents and the professional workers over the parents' reluctance to accept a recommendation to place their child in an institution. Other problems mentioned were "buck passing" from agency to agency (4), no appropriate resources (4), and duplication of tests and services (2).

Because this study was supported by the State of New York as part of its mental retardation program, the focus of the report was on developing general policy recommendations. But the concern here is with the use of these results by RIS in its own programming. The study has affected the agency in many ways, including the following:

1. The agency's decision to serve profoundly and severely retarded children over 5 years of age grew out of the findings showing the lack of adequate services for such children and their families. As a result of this decision, the agency extended its home aide services to provide training to parents of such children.

2. The agency's decision to undertake the research project on early identification in hospitals was supported by the parents' reports of delay in diagnosis.

3. The agency is negotiating to establish a facility where the retarded child may be left for a few hours, a day, several days, or even for short vacation periods.

Other new services or modifications of existing services will undoubtedly come about at RIS because of this and other studies. However, the significance of the RIS research experience derives not from any one study but from its demonstration that even small agencies with limited resources can develop a viable research program. Of course, the research must be guided in its goals by both the aims of the agency and the limitations of its resources. But it is certainly our belief that RIS would be a much poorer agency in programing and services if it had not made this commitment to research.

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PSYCHOLOGICAL CONSULTATION in a PRESCHOOL

LAWRENCE BALTER

A few years ago Lois Barclay Murphy wrote a clear and comprehensive article on the role of the consultant in a day-care center for deprived children.[1] The principles she pointed out apply equally well to the role of the psychological consultant in a nursery school for economically disadvantaged children.

Single instances aside, there tends to be a greater difference in role between the consultant in a private nursery school that caters to a middle-class clientele and the consultant in a preschool program established to serve children and their parents in low-income neighborhoods, especially those in which the children's parents and other members of the neighborhood play an active part.

The role of the preschool psychologist varies with the setting in which he is working. Among the factors influencing it are the location, the size of the facility, the number of children enrolled, their socioeconomic background, the sophistication and size of the staff, and the availability of competent members of other mental health professions.

Therefore, in discussing a psychologist's role in a nursery school it seems pertinent to consider two points: (1) his role in regard to problems that are peculiar to a preschool program for children of poverty; and (2) his role in building a positive relationship with the adults involved in the program—an essential part of the consulting role in any type of nursery school.

Before turning to the first point, a note of caution is in order. While the consulting psychologist by virtue of this training and experience may be in a position to conduct research, administer psychological tests, consult with teachers, parents, and children, and engage inservice training pertaining to child development needs in relation to curriculum, the nature of his role is essentially advisory. This means he offers information that is intended to be helpful to those with whom he works. Decisions on program or other school operations may be based in part upon his suggestions, but they are the responsibility of the school's administrator or director. Similarly, the choice of whether or not to follow the suggestions he may offer is the prerogative of the recipients. For him to assume otherwise would be presumptious as well as damaging to his role as a consultant.

Staff tensions

In a preschool for disadvantaged children in which the children's parents and other members of the community are actively involved, the staff may consist of persons varying widely in background, degree of training, and experience. Lines of authority and responsibility within the classroom may become blurred, resulting in interpersonal tension within the teaching staff. Actual leadership may not be the same as titular leadership. Such a confused situation may develop particularly in schools where the hierarchy of

the teaching staff has been casually set and where willingness of the staff members to talk openly of their problems is influenced by ethnic, social, racial, and personal factors. For example, a family liaison worker who works in the community where she lives and who is developing her skills while on the job, may be reluctant to discuss a problem she has encountered in the course of her work with the head teacher—the person to whom she is technically responsible. She may feel a great deal more comfortable consulting a staff member who is her neighbor and longtime friend.

Another source of tension can arise from the distribution of authority that favors formal education over experience. For example, a young middle-class person trained as a nursery school teacher may be appointed to the position of educational coordinator, or head teacher. She does not live in the community, she is single, and she is identified with middle-class mores. Working under her is a woman from the neighborhood who has been with the preschool for several years, has been an active participant at board meetings, has numerous social and political contacts in the community, and is a parent. Each may feel she knows best what the children need.

Unless the director understands the incipient conflicts in such situations, serious misunderstandings may ensue. The psychologist may point out these dangers and he may also help both the superior and subordinate broaden their perspectives and gain greater respect for one another's competencies. However, such situations also hold pitfalls for the psychologist, for he may find himself in a position similar to that of the young head teacher just described. I will explore this problem further when I discuss the "relationship" aspect of consultation.

Seminars, staff meetings, or conferences with the people involved often serve as useful vehicles within which to work out such problems. The formulation of new role definitions may in some instances make more sense than adhering to standard operating procedures. In any case, staff feelings, as well as reason, have to be taken into account.

Staffs that are composed largely of paraprofessionals from the neighborhood being served may be subject to frequent turnover in personnel. Some paraprofessionals move up the career ladder to administrative positions. Others leave because they become involved in other community activities when their own children "graduate" from the nursery school and enter public school. Still others leave because of pregnancy. Some intend from the beginning to stay only temporarily. Among these are the young people who leave to continue their education or enter other types of work and the free-lance artists who leave, return for a while, and then move on again. Some of the latter "creative noncompromisers," as Dr. Murphy has called them, have proved to be so gifted in dealing with young children that in spite of their tendency to wander, they usually are welcomed back.

Personnel changes in a preschool may have important effects on both the remaining staff and the children. They have to adjust to the loss of a familiar person and simultaneously accommodate to the addition of a new face and personality. Persons with little experience in work with children or whose sense of assurance depends for other reasons on a stable structure may become apprehensive. The continuity of the program may be disrupted. "Farwell" and "welcome" events may be both instructive and emotionally clarifying at such a time.

The consultant can be helpful by serving as a kind of stabilizer. Through group discussions, he can help the staff members maintain a sense of stability, provide the newcomers with a sense of what has been accomplished in the program and the rationale for its present activities, and buttress the efforts of the entire staff to progress toward previously agreed upon goals. He can work toward preparing the children in advance for the departure of one person and arrival of another and can help the staff anticipate the children's reactions to the change. He may also help staff members bring out their feelings about such changes in their working companions. When feelings are brought out, a reappraisal of the strengths and special skills of individual staff members evolves and even the program changes in the process of staff adaptation.

Parents and staff

In a preschool where parents are integrally involved in the school's functioning, it is common practice for parents to be invited to observe the children in the classroom and sometimes to work there as volunteers. This practice has many assets. However, misunderstandings on the part of both teacher and parent, or genuine disagreements between the two concerning the other's performance, are not unusual. Occasionally, too, personal hostility, unconscious rivalry, or other very human reactions may enter the picture. Often there develops a highly personalized problem where both persons are inclined to behave defensively. The parties in question may not have the

skill or experience to resolve the conflict successfully.

Here the consultant can make a major contribution by helping the parents and the staff members establish procedures together that facilitate communication between members of the two groups. Structural arrangements for problem solving, regardless of the type of problem, can be doubly useful. They provide not only a way for dealing with the conflicts they were established to resolve, but also an approach to resolution of future difficulties.

For example, most preschool centers hold regular staff meetings. In a parent-organized setting joint parent-staff meetings have proven to be a worthwhile approach to the solution of problems. In principle the idea is simple. However, in practice it may be extremely difficult to implement. Frequently, parents are reluctant to enter into discussions involving curriculum and staff members are equally reluctant to have "outsiders" sit in on discussions of curriculum and classroom management.

Whatever reasons for reluctance may be cited by either side, the goal of such meetings is to dissolve the notion of "sides" and to develop instead a unified working group of concerned adults. One way to help parents overcome their reluctance to attend such meetings is to offer them inservice training in child development and early childhood education so that they become sufficiently knowledgeable to feel confident and secure in discussions with the professionals. Despite the difficulties, the development of a joint staff-parent group has advantages far outweighing the problems of implementation.

A point of lesser importance concerns conflicts that may arise from overlapping roles. Some members of the instructional team may be parents of children who attend the school. Occasionally a child and his parent may be assigned to the same classroom. While this kind of arrangement may be worked out to meet a special situation in the family, it often presents problems for both the child and the parent and also for other children in the class. More rarely, a staff member who is also a parent of one of the children may be elected by the parents to serve on the governing board, a situation which may also result in discomfort, friction, and suspicion among the members of the teaching staff.

When such situations are imminent, the consultant may point out that an overlap in roles and functions contributes significantly to myriad problems. Such a step, however, must be taken prudently, as personal aspirations, political motivations, and other highly idiosyncratic factors may be at work.

Use of relationship

Whether the consultant addresses himself to matters of staff relationships, parent-staff involvement, program stabilization, or organizational issues, his effectiveness depends largely on the quality of the relationship he has developed with the nursery school as a whole and with its various component groups. The goal of developing a positive relationship goes beyond dealing with the issues that may arise, though this is certainly part of the goal. The ultimate purpose, however, is to help each person with whom the consultant works achieve independence and confidence in his own ability to function appropriately.

To achieve this goal the consultant must assume that the people with whom he works will develop a desire to take over *for themselves* and *as part of themselves* certain attitudes and modes of behavior that are actually part of the consultant's repertoire. Before those with whom he works see this goal for themselves, however, an intervening process of identifying with the consultant must occur, using his behavior as a model in the solution of problems. To the extent that the psychologist's attributes as a consultant are absorbed, each staff member is able to function as a consultant for himself.

Thus helping the consultee achieve identification with the consultant becomes a kind of subgoal. How to achieve a relationship that facilitates the process of identification is a question that cannot be answered easily or completely. Powerful forces operate continually to counteract the desired outcome. There are, however, several principles that are helpful in such an effort. For instance, a positive relationship depends in large part upon mutual respect and trust. The consulting psychologist comes to the preschool with a specialty that is the product of many years of formal training and experience. But this very background of formal training and professional ex-

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perience may in a sense be a handicap, for it may cause him to be perceived as a representative of the "establishment."

In some economically impoverished communities an association with the establishment conjures up negative stereotypes that sweep across any number of disparate individuals, groups, agencies, and institutions. The more pervasive the anti-establishment and anti-intellectual sentiment within the preschool and surrounding community, the greater the difficulty the consultant has in building the mutual respect and trust necessary for a positive relationship. Where such a general stereotype exists, the consultant will be unlikely to alter it appreciably. However, he may be able to free himself from this stereotype in the perception of those with whom he is working.

Whether the consultant is casual or relatively formal in his personal style, he may take several definite steps to promote the necessary confidence and trust. Because his role is never clearly defined, it need never become rigid. This makes his assimilation into the nursery school easier. The form of the assimilation may vary, but it should always serve to lessen the image of himself as an "outside authority" brought in to execute rapid solutions.

When the psychologist first comes to the nursery school, he may find it helpful to demonstrate some immediate usefulness by performing a specialized function such as psychological diagnosis or referral of children to community resources for needed services. More general duties such as pitching in wherever help is needed can also aid the assimilation process. Taking the initiative in arranging for a meeting or a workshop may also help. Such activities often give staff members a clearer idea of what the consultant can do or when to call on him. Needless to say, taking appropriate initiative requires good judgment and careful timing.

Of greater importance in the development of a relationship that lends itself to identification with the consultant is the *consistency* with which he maintains an *objective stance*. Whether the presenting problem concerns a teacher's handling of a child, a staff member's personal problem, or even a criticism of his own work, the consultant must attempt to examine the situation in a systematic and nonemotional fashion. He must make it clear to parents and staff members that, at least, he can be depended upon to (1) listen carefully to their expression of their thoughts and feelings; (2) uncover as many of the relevant facts as he can; (3) try his best to determine underlying as well as manifest contingencies; (4) look at the problem from various perspectives; and (5) respond and interpret the events according to his best judgment.

Such an approach is taken in the interest of helping his coworkers express their goals and work toward their stated objectives. In the process the consultant and the staff member involved explore alternatives and the possible consequences of any plan of action considered. In this way the consultant offers immediate assistance as well as a method that the staff member can use for himself in problem solving. Maintaining an objective stance, an understanding attitude, and an obvious willingness to help, the consultant works with the staff member in searching for potential solutions to whatever problems arise. Such a joint endeavor lays a foundation for the construction of a positive relationship, one that will facilitate the process of identification in the staff member and with it his gradual assumption of the consultant's role.

The foregoing description of the psychological consultant's role in developing a relationship with a nursery school staff member is but one feature of a multifaceted arrangement. There can be no effective relationship without a dynamic interchange among all members of the school staff. More than a mere reciprocity between consultant and staff is involved. The goal is for all staff members to become both recipients and givers in the consultation experience.

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[1] Murphy, Lois Barclay: The consultant in a day-care center for deprived children. *Children*, May–June 1968.

an essay review . . .

DEMOCRATIZATION OF EDUCATIONAL OPPORTUNITY

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Future historians who pursue a conspiratorial approach to the study of social phenomena may regard the great concern with ethnic desegregation in the mid-twentieth century as a ploy to divert attention from more critical problems in the democratization of educational achievements. Nonetheless, a careful reading of Weinberg's "Desegregation Research: An Appraisal"* and a serious analysis of the findings and judgments resulting from the research it reviews, inevitably lead to the conclusion that while ethnicity continues to be an important factor influencing *access to opportunity* in our society, *quality of opportunity* and utimately *quality of achievement* are largely functions of social class. Weinberg does not deal explicitly with this issue nor does he develop the argument. Rather, he confines himself to summarizing the major findings and trends in this field of research.

After reviewing the research on desegregation, Weinberg concludes, as have others,[1, 2] that ethnic integration in public schools is clearly associated with gains in achievement for black children but not so clearly for native American (American Indian) or Mexican-American children. White children involved in desegregation experiences—more advanced from the start than the children from the ethnic groups—continue to learn at their accustomed rates.

Weinberg presents a number of other findings. But if one moves from this central finding to a consideration of policy implications, it becomes clear that an indicated treatment for low academic achievement among children from minority groups is the integration of these children in learning situations with children of the majority. However, the simple moving of ethnic groups apparently is not adequate. Other findings in the research Weinberg reviews suggest that success depends on important conditions: (1) that the children of higher social status remain in the majority in the school; (2) that resegregation within the integrated setting be avoided; (3) that a systematic educational program be available; and (4) that the politico-social climate not be so chaotic as to preclude attention to academic learning.

The research reviewed clearly shows that ethnic integration in education is associated not only with improvement in academic achievement, but also with higher levels of aspiration and self-esteem in the minority group children. Improvement is also reported in the attitudes of students of the two groups toward each other as well as between students and teachers who are of different races. As Weinberg points out, "virtually none of the negative predictions (advanced) by anti-desegregationists find support in studies of actual desegregation."

Mechanisms of change

As evidence in support of these findings and observations mounts, researchers begin to turn from a preoccupation with the identification of correlations to a concern with the mechanisms by which the improvement in relationships may be explained.

It is here that the emphasis on ethnicity may be counterproductive. If we conclude that something about the other children's being white improves the functioning of black children in integrated settings, we must also accept certain assertions concerning white supremacy and end up in open conflict with some of the assumptions that led us to move toward integration in the first place. We are also in open conflict with the ethnic culturalist and ethnic nationalist movements that in and of themselves may be potent forces for the improved development of black children.

Any assumption about the intrinsic goodness of whiteness for the educational development of black people is untenable. However, there are factors associated with being white and middle class in our society that can help explain the improved achievement of black children in predominantly white schools. One does not need to be an expert to think of a few of these: better school facilities, better and more stable teaching staffs, higher expectations of achievement, greater pressure on the school to produce, the sense of being well situated and possibly even capable of influencing one's future, to mention a few. These conditions derive from social status or class and are related to race only as race contributes to the differential allocation of status in our society.

When one goes back to the school desegregation data reviewed by Weinberg and examines the probable contribution of economic status to the association between desegregation and achievement among black children, the possible contribution of ethnic factors becomes unimpressive. However, in our social order, unfortunately, one cannot completely separate economic and ethnic status. The pervasiveness of racism hopelessly confounds the two.

*DESEGREGATION RESEARCH: AN APPRAISAL. Second edition. Meyer Weinberg. Phi Delta Kappa, Bloomington, Ind. 1970. 460 pp. $3.75

Nevertheless, it is of great practical significance to distinguish between ethnicity and class as explanations of differences in access to and quality of opportunity. As long as we focus our attention on ethnicity and ignore socioeconomic status, we fail to see the following important facts:

- Academic underdevelopment is not limited to blacks and other ethnic minorities.
- Although black children improve in achievement following desegregation, the desegregated educational experience is not associated with an equalization of achievement.
- The effects of assigned social status and perceived differences in social conditions result in varied patterns of performance among children from lower status groups.
- It is unlikely that an adequately desegregated educational experience can be made available or acceptable to all minority group children in the Nation.
- The quality of educational opportunity and the quality of achievement are apparently advancing at a more rapid rate among children of the most privileged segments of our population than among the masses.

Some political pressures

Attention to these issues forces a consideration of the political economy of education. What is the relationship between economic values, political control, and distribution and quality of educational opportunity?

Access to the formal educational resources of societies has always been determined by the nature of the social order's need for educated or trained people. Who gets educated and how well they are educated depends on what the controllers of political power deem to be the requirements for the maintenance and orderly advancement of the society.

In the United States, the desegregation of the public schools could not emerge as a national issue until the political and economic requirements of the Nation demanded it. Universal literacy is essential for a nation in the advanced stages of industrialization, and the opening up of access to educational opportunity to all ethnic groups is an essential feature of a great power that needs friends in all parts of the world. Such needs can help us understand the heavy emphasis on desegregation in the presence of gross and increasing inequities in the *quality* of opportunity available to children of different classes.

Weinberg reminds us that our national economy "requires specialists and manages to influence the educational structure of the country to accommodate to this need." But he fails to point out that we do not need a *mass* population of specialists and highly skilled professional and technical workers. In the absence of such a need, our schools have not been forced to equalize the quality of educational opportunities on a universal basis.

Regarding quality

We could continue to be selective and provide high-quality education for those middle- and upper-class members of society who want it and those lower-class and lower-status members whom we select. However, the political pressures for universal access to educational opportunity, once aided by international politico-diplomatic needs, now continue largely as a reflection of exacerbated domestic political demands. In response to these pressures, we democratize *access* to education through desegregation of the public schools and open admission to college without dealing with the basic problems of democratizing the *quality* of educational opportunity and ultimately the quality of achievement in our society.

To tackle these problems requires the restructuring of education, the redefinition of educational goals, and changes in society. If the Coleman data [3] can be relied upon, four factors emerge as highly important to school achievement: (1) family background; (2) the extent to which a pupil feels that he has control over his own destiny; and (3) for children of low-status groups, the extent to which one's schoolmates are privileged in status and (4) the quality of the educational experiences.

To manipulate the factor of family background in the interest of improving educational achievement requires improving family income, social status, and quality of life.

To modify feelings regarding the control of one's destiny in the interest of educational achievement requires modification of the distribution of power to reduce feelings of powerlessness among people.

To insure pupils' achievement according to existing norms requires ethnic integration since there are not enough middle- and upper-class people in the minority groups to achieve the indicated mix of high- and low-status children in segregated settings. But the subtle imposition of such norms may be not only unacceptable to many members of these groups but also counterproductive to their development. We may need to change radically our criteria for educational experiences of high quality and high quality of achievement.

Perhaps society's perceived need for specialists and persons of high technical skill is in error. Could it not be that the 21st century will demand intellectuality—the competence to pose appropriate questions, to organize experiences and information in the solution of problems, and to synthesize knowledge, experience, and values into wisdom? Could it not be that the next century will also require competence in self-expression and self-management in cooperative relations with others in creative and recreative pursuits?

To pursue such goals the structure and methods of schooling will have to be changed. Schooling of high quality will have to be concerned with the development of intellect and values, and not so much with the integration of races and cultures as with its own integration with life and its pupils' integration of their lives. With such goals, education could replace economics and even politics as the ordering force of society, for the quality of achievement would then be measured by the quality of *life* available to all men.

Desegregation of the public school may be a step toward such goals. The reordering of priorities — social and pedagogical—the restructuring of education, and the more equitable distribution of power and resources must follow.

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[1] St. John, Nancy H.: Desegregation and minority group performance. *Review of Educational Research*, February 1970.

[2] Pettigrew, Thomas F.: Race and equal educational opportunity. *Harvard Educational Review*. Winter 1968.

[3] Coleman, James S.: Equality of educational opportunity. U.S. Department of Health, Education, and Welfare, Office of Education, Washington, D.C. 1966.

The Use of Stimulant Drugs in Treating Hyperactive Children

Diagnosis and close supervision by a physician and parental understanding and cooperation are keys to the proper administration of amphetamine drugs in the treatment of school-age children who have hyperkinetic behavioral disturbance, according to the report of a multidisciplinary panel of professional persons issued by the Department of Health, Education, and Welfare in early March. The report is the result of a 2-day conference called by the Office of Child Development and the Office of the Assistant Secretary for Health and Scientific Affairs to review the evidence of research and experience in the appropriate use of psychotropic drugs in treating school-age children.

Chaired by Daniel X. Freedman, M.D., who heads the Department of Psychiatry at the University of Chicago, the 15-member panel represented the fields of education, psychology, special education, pediatrics, adult and child psychiatry, psychoanalysis, basic and clinical pharmacology, internal medicine, and social work.

Pointing out that hyperkinetic behavior disturbance affects about three out of 100 elementary school children and is characterized by poor attention, disordered behavior, and excessive activity, the report stresses the importance of skilled diagnosis in identifying the condition. Among its conclusions are these:

- In many children with diagnosed hyperkinesis, the use of certain amphetamines, or stimulant drugs, improves attention, learning, and social abilities. Such drugs do not cure the condition but make the child more accessible to educational and counseling efforts. They have been found to benefit about half to two-thirds of the cases in which trials of the drugs are warranted.
- Before treatment is undertaken, diagnosis of a child with a behavior problem should take into account the child's environment, family relationships, and other physical and psychological factors. Adequate diagnosis may, therefore, require the use of psychological, educational, and social as well as medical resources. The use of amphetamines is clearly not called for in children whose behavioral disturbance stems from hunger, emotional stress, poor teaching, or crowded classrooms.
- Amphetamines do not act as sedatives in children; rather they appear "to mobilize and to increase the child's abilities to focus on meaningful stimuli and to organize his bodily movements more purposefully." Unwarranted side effects are rare in the small doses used in the medical treatment of children and disappear with cessation of treatment.
- Thirty years of medical experience in using stimulant drugs in treating hyperkinetic children has produced no evidence that the children so treated have become drug abusers in later life. Dosages used in medical therapy are small in comparison with the dosages taken by drug abusers.
- While it is entirely proper for school teachers or administrators to draw parents' attention to a child's behavior problems, they should scrupulously avoid any attempt to force parents to accept any particular kind of treatment and should initiate contact with a physician only with the parents' consent. In any instance, treatment should be undertaken only with the informed consent of the parents and of the child if the child is old enough to understand.
- The child should not be given the sole responsibility for taking his medication. In most cases, it is not even necessary for the child to take the drug to school. The same precautions should be taken in the home against the misuse of amphetamines by children as against the misuse of any other medication.
- No stigma should be attached to a child who has been prescribed medication for behavior disorders: "his situation is no different from that of the child who benefits from eyeglasses."
- Manufacturers of stimulant medications should promote their products solely through the appropriate medical channels and should not seek the endorsement of such products from school personnel.
- Abuses and misuses of drugs with children must promptly be called to the attention of the proper authorities. Physicians, educators, parents, and the news media share this responsibility.

The report also emphasizes the need for further research into causes, prevention, and treatment of all types of behavior disorders in children. It points out that, even when medication has improved the behavior disturbance, a child may require special attention for coexisting disorders—such as perceptual and learning problems—as well as for psychological, social, and family problems.

The panel warned against the use of amphetamines with restless school children as a substitute for improving the schools. It also warned against allowing negative public attitudes toward the appropriate use of drugs to deprive children of needed medication: "Either bad practices or exaggerated alarm can threaten the availability of medical resources for those who critically need it."

For a copy of the full report, send a postcard to Drug Panel Report, Office of Child Development, P.O. Box 1182, Washington, D.C. 20013.

DRUG PANEL

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HERE and THERE

Conference followup

As a first step in putting the recommendations of the 1970 White House Conference on Children into action, delegates to five regional followup meetings, held between February 20 and March 3, 1971, suggested that the 55 State Committees on Children and Youth be strengthened and those now operating under temporary appointments be established on a continuing basis. The National Council of State Committees for Children and Youth cosponsored the regional meetings with the White House Conference. Both are offering to help State groups work with legislatures and governors to achieve this goal. More than one-third of the State committees were created on a temporary basis.

Altogether nearly 1,000 delegates attended the meetings, which were held in Omaha, Denver, Indianapolis, Atlanta, and Seattle. The delegates, were selected by the State committees.

Each regional meeting was focused on the development of strategies for implementing the recommendations of the White House Conference. Many of the delegates agreed that local conditions would determine the specific action taken in local communities. Among the methods suggested for initiating change were efforts to increase understanding by holding open houses and special tours of children's institutions and environments, recruiting volunteer workers—particularly the members of the lawmakers' families, young people, and children—and presenting discussions about services for children on television and in newspapers.

Other methods suggested for citizen action were conferring with government officials on programs and policies and lobbying with city or county governments, State legislators, and Congressmen for legislation to meet children's needs.

Naomi Hiett, director of the Illinois Commission on Children, was chairman of the national committee for the regional meetings. Each meeting also had a regional planning committee.

Health Start

Health Start, an experimental program to extend comprehensive health services to disadvantaged preschool children not now receiving health attention, will be launched by the Office of Child Development in the summer of 1971 in 20 to 30 communities across the Nation. Initially, it will bring health care and health education to about 10,000 children under 6 years of age, including brothers and sisters of children currently enrolled in Head Start programs, children on waiting lists for enrollment in Head Start, and other children from low-income families who need health services.

In addition to increasing the number of children who receive health services, the Health Start program is intended to develop various methods of ensuring delivery of health services to children in communities with limited health resources. Projects are expected to draw on the resources of other programs, including Head Start health services, Parent and Child Center health services, comprehensive health care projects for children and youth, Medicaid, and the compensatory education programs established under the Elementary and Secondary Education Act.

All Health Start models will provide the following services for each child: screening tests to detect developmental problems; physical examinations; vision and hearing tests; immunizations; routine laboratory tests and special tests for intestinal parasites, sickle cell anemia, and lead poisoning when indicated; dental care; and linkages for continuing health services, including the forwarding of records to schools, neighborhood health centers, or other interested agencies. While most projects will run for 4 to 8 weeks, treatment services will be continued under a long-range followup plan until the child's needs are met.

Health education for children, their parents, and staff members will also be an integral part of each model. The curriculum will include information about the human body, disease prevention, nutrition, dental hygiene, and other aspects of health.

Each project will be directed by a health coordinator—in most cases, a registered nurse with experience in administration, teaching, and counselling. Where a registered nurse is not available, a licensed practical nurse or other experienced health worker will be employed. The coordinators, to be employed for a full year, will be given preservice training in methods of providing Health Start services, coordinating and supplementing local health resources, and completing health service requirements of the program.

Grants for 1971 Health Start projects will be made in at least two communities in each of the 10 HEW regions. Applications, which closed on May 15, are now being reviewed, and the grants will be awarded June 1.

Gertrude T. Hunter, M.D., director of health services for Head Start, is national coordinator for the Health Start program.

Quasi-adoption

A quasi-adoption program, initiated in 1964 by the Children's Aid Society of Pennsylvania for black children in Philadelphia, has worked out well, according to a study conducted by the Society and Bryn Mawr College. The program subsidizes families with whom children are placed with an understanding that the subsidized family will care for the child through his childhood and perhaps legally adopt him.

Supported by a grant from the Children's Bureau, the study compared 43 children between the ages of 3 and 6 in the quasi-adoption program with 39 black children in the traditional adop-

tion program placed between September 1, 1964, and September 1, 1968. All the children in both groups had been placed with black couples.

The subsidized parents were slightly older and had slightly lower incomes than the parents taking children for adoption.

The investigators found that families in both programs showed high levels of family and child functioning. In rating the parental functioning, based on such qualities as acceptance of the adoptive role and affection, the study team gave the highest score possible to 77 percent of the mothers in the quasi-adoption program and 92 percent of the mothers in traditional adoption.

The study found no significant difference in the overall adjustment of children in the two groups as determined by interviews with parents, observations by the study team, and psychological tests of the children. In the area of intelligence, however, the adopted children scored higher than the children in quasi-adoption, who were older at the time of placement and had a greater number of negative factors in their lives.

In quasi-adoption, the agency retains responsibility until the child grows up or is legally adopted. Both groups of parents in the study received about the same number of supportive services related to family functioning from the agency. However, 98 percent of the permanent foster parents received financial help from the agency, compared with 5 percent of the parents in traditional adoption.

Elizabeth A. Lawder, D.S.W., executive director of the Children's Aid Society of Pennsylvania, was director of the research team.

Mental retardation

A system for providing comprehensive health care in residential institutions for the mentally retarded has been designed by Harold A. Decker, M.D., formerly of the School of Public Health, University of Michigan, on the basis of two studies of health care in such institutions carried out under his direction from 1965 to 1969. The studies received support from the Children's Bureau, the Maternal and Child Health Service of the Health Services and Mental Health Administration, and the National Institute of Child Health and Human Development.

The first study consisted of data gathering from 1965 to 1967 on the health status of 304 children age 12 or younger in a Michigan institution for the retarded. Pediatric assessments revealed that while the children had little acute illness, most of them (250) suffered from one or more physical or sensory defects. Many of these defects had arisen as complications of chronic conditions that presumably had had insufficient attention to prevent deterioration. In the course of the study, 69 percent of the children were referred to specialists for examinations, resulting in more than 600 modifications in their individual care programs.

The investigators noted several obstacles to providing individualized preventive, curative, and rehabilitative health care in an institution for the retarded: (1) a tendency to program for "blocks" of children, (2) the use of the physician's time on an *ad hoc* basis, (3) a shortage of staff and funds, and (4) a failure to maintain close liaison with the providers of care.

The second phase of the study, which took place from 1967 to 1969, sought to document the characteristics of the systems of health services in five institutions for the mentally retarded and the patterns of care they rendered. The investigators found that although each institution reported that multidisciplinary care was its ideal, practices in fact leaned to one or two professional approaches; diagnostic evaluations were rarely followed by long-term plans for treatment; reevaluations tended to include fewer categories of professional assessment than initial diagnostic examinations; and long term patients tended to receive fewer services than recently admitted residents.

On the assumption that all residents of such institutions have a basic right to comprehensive, coordinated, individually planned, continuing health care, Dr. Decker proposes a system that includes provisions for: (1) appraising each resident's present clinical status and level of functioning, (2) establishing individual health and rehabilitation goals and a plan of care for each patient through interdisciplinary resident-care planning conferences, (3) following up to see that the plan is implemented, and (4) reevaluating the plan periodically and making indicated revisions.

The proposed system, with appraisal and report forms, is contained in a monograph, "A System for Planning and Achieving Comprehensive Health Care in Residential Institutions for the Mentally Retarded," by Harold A. Decker, available on request from Dr. Decker, who is now at the Department of Pediatrics, University of Arkansas Medical Center, 4301 West Markham Street, Little Rock, Ark. 72201.

Overweight teenagers

What an overweight teenager needs before he can reduce is "moral treatment"—acceptance by other people, especially those of their own age, on the basis of his own personality and capabilities, according to Werner J. Cahnman, Ph. D., professor emeritus of sociology at Rutgers University. His conclusion is based on a recently completed retrospective study of the sociogenic factor of personality development in six young people who were obese in childhood and adolescence. He found that his subjects experienced a sense of inadequacy and a lack of self-confidence as a result of prejudicial attitudes but responded to social acceptance by losing weight.

The subjects included one male and five females between the ages of 17 and 24 at the time of the study who were interviewed orally and by a written questionnaire about their earlier relationships and attendant feelings. Five had remained overweight, but all had periods of losing weight when they were accepted by their peers.

Each participant reported remembering the incident in late childhood or early adolescence in which he first became aware of being "fat" and therefore "different." All reported feelings of embarrassment, hurt, anger, guilt, and shame. Most of them said they reacted to an insult or comment about weight by increasing food intake and so gaining more weight. Some of the participants reported that their school grades improved in periods of weight loss and declined in periods of weight gain.

Dr. Cahnman points out that overweight adolescents come to believe that others are "right" and that they "deserve" discriminatory treatment. He reports that the young people in his study chose various ways to retreat from society—becoming a comedian, escaping into intellectualism, alternating between

passivity and boisterousness, making exaggerated attempts to please others, manifesting a belligerent "chip on the shoulder" attitude, or refusing to accept criticism and to face facts.

The participants suggested, among other approaches to problems of obesity, an attack on the psychological and sociological causes not merely on its symptoms; education of other teenagers and parents about some of the problems of a fat person; and concrete ways of helping the overweight person gain confidence in himself. One girl said that the biggest problem of overweight people is their own defeatist attitude.

A mimeographed copy of the study findings, including the verbatim comments of the participants, is available from Dr. Werner J. Cahnman, 67–71 Yellowstone Boulevard, Forest Hills, N.Y. 11375. ("The Stigma of Overweight: Six Autobiographies," 20 cents in stamps or coins.)

Marijuana

The use of marijuana cannot be linked to birth defects, chromosomal changes, cancer, or commission of violent crimes on the basis of available scientific evidence, according to the first annual report on marijuana and health, submitted to Congress by the Department of Health, Education, and Welfare February 1. The report points out that although there is a substantial body of information about marijuana, present knowledge is "fragmentary" and much of it is of limited relevance in determining the long-term health implications of use.

The difficulties of obtaining reliable information about the effects are compounded by the fact that varying mixtures of the drug have psychoactive properties "ranging from virtually nonexistent to decidedly hallucinogenic in its stronger forms and at high dosages." The report points out that the form in which the drug is consumed, as well as the behavioral makeup of the user, will also affect the consequences of use.

The report cites studies showing that by the end of 1970, about one college student in seven was using marijuana weekly or more frequently, and 31 percent of all college students had used it at some time; and that while use by high school students has generally lagged behind use by college students, in some high schools one-third to one-half of the students have experimented with marijuana. The report suggests that the levels of marijuana use among school dropouts are "probably higher" than for high school students. One of the studies cited found that in some communities of hippies, 95 to 100 percent of the residents have used marijuana.

Studies of junior and senior high school students in San Mateo County, Calif., show relatively high levels of marijuana use, with large increases in 1968 and 1969, but a decidedly smaller increase in 1970. The students in the county's seventh and eighth grades used less marijuana in 1970 than in 1969—a statistic the report finds "an interesting change" that "may presage a stabilization of rates or a possible decline in interest among students."

The report warns against the use of any drug of unknown teratogenic or mutagenic properties during the childbearing years, especially during pregnancy. It also discusses natural and synthetic marijuana, preclinical studies in animals, effects in man, social and cultural concomitants, and research needs. The 176-page report, "Marihuana and Health," may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. ($1.50.)

Health protection

A National Commission on Venereal Disease was created in February by the Department of Health, Education, and Welfare to develop a national strategy for combating gonorrhea and infectious syphilis, estimated to have affected 2 million and 75,000 people, respectively, in the United States in 1970.

The commission will consider the problems behind the rapid rise in the incidence of both diseases in the past year (See CHILDREN, November-December 1970, p. 240); study ways of bringing public health and private medical practitioners who come in contact with the diseases into a closer working relationship; and make recommendations for bringing both diseases under control. A 1968 survey shows that physicians in private practice treat about 80 percent of the cases of VD but make official reports on only about one case in nine.

Bruce Webster, M.D., president of the American Social Health Association, is chairman of the new commission. Other members include the surgeon general of the United States and representatives of professional, medical, and public health organizations and the U.S. Armed Forces.

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The executive board of the American Public Health Association has issued a statement recommending that "safe, accessible abortion services" be "an integral part of comprehensive family planning and maternal and child health care," and be made available at reasonable fees for all who are in need of such services.

The board specifically recommended referral and counseling services for persons seeking abortions; public education about abortion procedures and services; and, when abortion is requested, surgical care by a qualified physician, preferably an obstetrician-gynecologist, and before the end of the third month of pregnancy.

The board stressed the importance of performing any abortion done after the 12th week of pregnancy as an inpatient procedure in a hospital. It also recommended that all abortions be reported to local and State health departments for compilations of statistical data but that confidentiality on individual cases be maintained.

(Address: American Public Health Association, Inc., 1740 Broadway, New York, N.Y. 10019.)

Early education

A home-oriented early childhood education program is the most effective way to reach rural preschool children in Appalachia, according to the preliminary conclusions of a 3-year field test begun in 1968 by the Appalachia Educational Laboratory of Charleston, W. Va., one of 15 educational research laboratories funded by the U.S. Office of Education.

The program reaches children in remote areas through a mobile classroom, daily television lessons broadcast on both commercial and educational channels, and paraprofessional child educators who offer individual guidance to mothers and children during weekly visits to their homes. The cost of the program is less than half as much per child as a conventional kindergarten, according to Roy Alford, Ed. D., co-

ordinator of early childhood education for the laboratory.

About 750 children in West Virginia's Fayette, Mercer, Raleigh, and Summers Counties have participated in some phase of the field test or have served in the control group. Each school year since 1968–69 the primary test group has included about 150 children—divided equally between 3-, 4-, and 5-year-olds. When the previous year's 5-year-olds enter school, a new group of 3-year-olds is enrolled.

A total of 325 television lessons have been shown during the field test. All have been created by the laboratory's curriculum materials team to prepare isolated rural preschool children for the first grade. The team also has developed a weekly newsletter for parents, printed guides for teachers and paraprofessional workers, and visual materials for children.

Tests show that children who have participated in all three components of the program have benefited more than those involved in only two components. Eighty-nine percent of the mothers have reported that they watch the television lessons with their preschool children, and almost all use the educational materials distributed by the paraprofessional workers.

The laboratory staff has prepared reports on deve'opment of the program, and will provide television lessons, written materials, and consultation to educational agencies in other parts of Appalachia. (Address: Appalachia Educational Laboratory, Box 1348, Charleston, W. Va. 25325.)

Delinquency treatment

A 16- or 17-year-old delinquent boy who possesses ego strength and personal resilence may profit from confrontation with his peers in a group treatment program but a similar experience may harm a less socially assertive or younger boy, according to a study recently reported by the California Youth Authority. The study was the second part of an evaluation, carried out between 1964 and 1968, of a 90-day preparole program known as the James Marshall Program, at the authority's facility at Norwalk.

The study found that 72 percent (88) of a group of 123 boys who had been in the Marshall program were removed from parole for violations in the 15 ensuing months, compared with 56 percent (69) of the 123 boys in a matched control group who had been in other correctional institutions in California for an average of 7 to 9 months.

The report attributed the higher violation rate of the Marshall group to the extremely high rate of failure among lone offenders—about four-fifths of the 54 "loners" violated parole. However, the significant difference in failure between the Marshall and the comparison groups disappeared when violation rates were recomputed with lone offenders excluded from both groups. The study indicated that loners tend to become more alienated from authority in confrontive situations. It also found that boys who are perturbable, problem bound, and non-assertive were not amenable to the Marshall program.

One group of Marshall boys who had a violation rate lower than the control group—33 percent as compared with 58 percent—consisted of 16 boys who were 16 or 17 years of age and who had had at least two companions when they committed their offense.

For the less assertive, threat-sensitive, or younger boy, the report suggests as an alternative to intensive confrontive treatment, a supportive program emphasizing desired behavior and "normalizing" experiences. It also calls for continuing investigation of the kind of boy—or kinds of boys in combination—who is most likely to benefit from deviance-probing delinquency treatment.

The report of the study, "Amenability to Confrontive Peer-Group Treatment" by Doug Knight, is available as Research Report No. 59 from the California Youth Authority, 714 P Street, Sacramento, Calif. 98514.

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guides and reports

TEACHERS AND THE CHILDREN OF POVERTY. Robert Coles, M.D. The Potomac Institute, Inc., 1501 18th Street, NW., Washington, D.C. 20036. 1970. 111 pp. $2.

Contains suggestions for reaching and teaching poor innercity children who are low achievers, based on a study of special school programs in 13 cities; includes drawings by some of the children interviewed.

HEALTH CARE OF CHILDREN: a challenge. Hortense S. Cochrane in collaboration with Theodore DiBuono, M.D. Foreword by Julius B. Richmond, M.D. Syracuse University, School of Social Work, Syracuse, N.Y. 13210. 1970. 85 pp. $2.50.

Directed to persons engaged in child care services, this pamphlet discusses the health needs of preschool children and the appropriate use of health and medical resources.

INDUSTRY AND DAY CARE: proceedings of a conference. Urban Research Corp., 5464 South Shore Drive, Chicago, Ill. 60615. 1970. 88 pp. $15.

Proceedings of a 1970 conference of 175 representatives of industry and of community agencies, early childhood specialists, and day-care center operators, to discuss industry's role in helping to meet the need for day-care services.

ACADEMIC CHILD PSYCHIATRY. Paul L. Adams, Henry H. Work, and Joseph B. Cramer. The Society of Professors of Child Psychiatry, Children's Mental Health Unit, University of Florida, Gainesville, Fla. 32601. 153 pp. $3.50.

Consists of 10 papers presented at a Conference of Academic Child Psychiatrists at the University of Florida in 1969, including academic child psychiatry's relation to community mental health centers; clinical services; medical education; research; and teamwork with social workers, psychologists, and others in paramedical professions.

BOOK NOTES

HOW THEY FARED IN ADOPTION: a follow-up study. Benson Jaffee and David Fanshel. Columbia University Press, New York, N.Y. 1970. 370 pp. Cloth $13.50, paper $4.95.

This book reports on a study of how 100 adoptive families perceived the development and levels of adjustment of their children 20 to 30 years after the initial placement. Conducted in the mid-1960's for the Child Welfare League of America, the study was designed to identify (1) parents who have reared their adoptive children with relative success, and (2) variables associated with outcome of adoption.

The study was based primarily on interviews with 89 adoptive mothers and 73 adoptive fathers of Caucasian children placed by four New York City agencies between 1931 and 1940. All the children were under 3 years of age at the time of placement.

The research team rated the families on 37 items, reviewed available case records, and interviewed 33 of the "adoptees." At the time of the study, 65 of the adoptive couples were still together; the adoptees (49 boys and 51 girls) were young adults—71 were married and 19 were still living at home.

The families were divided into low-problem, middle-range, and high-problem groups on the basis of overall adjustment of the adoptees as reported by their parents.

The research team was particularly concerned with the way the children were told about adoption and how the telling affected their later adjustment. Parents reported that 44 of the children had "always known" of their adoptive status. For the 56 other adoptees, the study did not find a significant relation between the manner of revelation (source, age of child, circumstances) and outcome of adoption, with one exception. Children who expressed curiosity and anxiety about their biological parents had significantly more problems of adjustment than other children.

Four of the adoptees, now young adults, had never been told that they were adopted. Of these, two were in the low-problem group, and one each in the middle-range and high-problem groups.

The study showed that 9 out of 10 families appeared to retain an enthusiasm about adoption and three-fourths of the couples said they had had no problems specifically related to the child's adoptive status.

The authors recommend that adoptive agencies (1) maintain contact with a cross-sectional sample of adoptive families after final adoption is completed in order to become experts on adoptive family life, and (2) provide counseling and other clinical services to adoptive families.

ADOPTING OLDER CHILDREN. Alfred Kadushin. Columbia University Press, New York, N.Y. 1970. 245 pp. $10.

In this book, the author, professor of social work at the University of Wisconsin, reports on a followup study of adoptions of children who were 5 years of age or older at the time of placement. The 91 children, all Caucasian, were placed by the Wisconsin State Department of Public Welfare between 1952 and 1962. As a result of the study, made about 6 years after placement, the author concludes that older children can be placed for adoption with a high probability of success, although he points out that some failures are inevitable.

The study, supported by a grant from the Children's Bureau, involved 49 boys and 42 girls who had been removed from their parents by court action because of neglect or abuse. Subsequently they were placed in foster homes, averaging slightly more than two foster homes per child, before being placed for adoption. Most of the children and adoptive parents adjusted readily to the adoptive placement, and three-fourths of the adoptions were completed in 2 years.

At the time of the study all the children had accepted a change in last name, seemingly without conflict. However, two children had been removed from adoptive homes.

Data for the study were obtained from joint interviews with both adoptive parents about their experiences, satisfactions, and dissatisfactions; written comments; and agency records.

The author found that outcome of adoption is more likely to be favorable when the child has been able to develop interpersonal relationships and when adoptive parents have accepted the child and perceived him as a member of the family. Conversely, he found that adoption outcome is less likely to be favorable the older the child, the more temporary placements he has experienced, and the more disturbed behavior he has shown.

The author found that as a whole the children showed a greater degree of psychic health and stability than might have been anticipated from their early lives: 79 percent of the children were rated as capable of developing good or fair interpersonal relations. Noting that such children, when provided a healthy environment, have been able to surmount the damages of earlier traumatic experiences, he concludes that environment is a major determinant of developmental outcome.

SUMMERHILL: for and against. Nathan W. Ackerman and others. Hart Publishing Co., Inc., New York, N.Y. 1970. 217 pp. Cloth $7.50, paper $1.95.

This book of 15 essays by educators, psychologists, sociologists, and journalists reviews the opinions of American educators regarding A. S. Neill's philosophy 10 years after the U.S. publication of his book, "Summerhill: A Radical Approach to Child Rearing." In evaluating the success of Summerhill—the English boarding school for disturbed children in which Neill provides an environment of unusual freedom—the authors present a broad spectrum of current ideas about American education.

Rev. John M. Culkin, S.J., finds Summerhill "a holy place." Also "for" the school are Nathan W. Ackerman, Sylvia Ashton-Warner, Bruno Bettelheim, Erich Fromm, Paul Goodman, John Holt, Eda J. LeShan, Ashley Montagu,

Ernest Papanek, Michael Rossman, and Goodwin Watson. Several of these authors identify Neill's deep respect for the child as one of the strengths through which Summerhill develops happy, alive human beings.

Only one author—Max Rafferty—is completely "against" Summerhill's methods; he calls the institution "a caricature of education." Two other authors—Louise Bates Ames and Fred M. Hechinger—express both reservations about the school's anti-intellectualism, and admiration of its headmaster's dedication.

SCENE OF THE BATTLE: group behavior in urban classrooms. Joan I. Roberts. Doubleday and Co., Inc., New York, N.Y. 1970. 441 pp. $8.95.

Improving the quality of student-teacher relations in classroom groups is basic to stopping the battles that interfere with learning in innercity schools, says the author of this book. A social psychologist, she developed her thesis—that teachers fail because they do not understand or utilize group behavior productively in leading their students—while participating in Project True (Teacher Resources for Urban Education) at Hunter College.

The author presents brief descriptions of more than 400 separate observations of classes in action made by five educators as part of the project in four junior high schools in low-income areas in New York City. Then she discusses the ways teachers function, class structure and its relation to anger and apathy in the students, relevant and irrelevant classroom goals, dehumanizing classroom norms, and the stifling effects of educational bureaucracy. She maintains that one of the sources of conflict between teachers and students is the imposition of middle-class goals on children from low-income families.

RECREATION AND LEISURE SERVICE FOR THE DISADVANTAGED—guidelines to program development and related readings. John A. Nesbitt, Paul D. Brown, James F. Murphy. Lea & Febiger, Philadelphia, Pa. 1970. 593 pp. $14.50.

The book presents guidelines for developing recreation services for children and adults in innercity areas along with readings identifying procedures, programs, and suggested activities.

It recommends that public recreation departments—

- Recognize the inability of disadvantaged persons to purchase services, equipment, and other necessities of a good recreation program.
- Use sound procedures for determining the recreational needs of specific communities.
- Evaluate program effectiveness.
- Involve the disadvantaged in every step of programing.
- Respect the value systems of the persons served.
- Integrate staff.
- Publicize staff openings in areas where the disadvantaged live.
- Provide inservice training to increase staff awareness of the needs of members of the disadvantaged community.

The 54 readings provide philosophical, sociological, historical, and contemporary perspectives to many of the points made in the guidelines.

PET-ORIENTED CHILD PSYCHOTHERAPY. Boris M. Levinson. Charles C Thomas, Publisher, Springfield, Ill. 1970. 202 pp. $9.75.

The use of pets in the treatment of children with emotional difficulties is described in this book by the psychologist who developed this method of psychotherapy. He points out that the pet becomes, in a sense, "the mirror in which the child sees himself wanted and loved not for what he should be . . . but for what he is."

According to the author, the presence of a dog, cat, or other pet in therapy enables the child to project feelings that would be unacceptable if projected toward humans; meets the child's needs for cuddling, companionship, and unconditional acceptance; and provides the child with an opportunity to feel that he is master of his situation. The author warns that assigning a pet to an emotionally disturbed child without at the same time providing for psychotherapeutic intervention can be harmful to both the child and the pet. If, however, the pet is introduced into the family after careful planning and the child is guided into learning how to master the pet, the child also learns how to master his own anxieties.

Through short case histories the author illustrates his thesis that pets are invaluable aides in treating young nonverbal, inhibited, autistic, withdrawn, obsessive, compulsive, and culturally disadvantaged children. He suggests that pets may be used beneficially in residential treatment centers for emotionally disturbed children; in hospitals for children with lengthy illnesses; in training schools for physically or mentally handicapped children; and in day schools for exceptional children.

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for parents

THINKING IS CHILD'S PLAY. Evelyn Sharp. E. P. Dutton & Co., Inc., 201 Park Avenue South, New York, N.Y. 10003. 1970. 157 pp. $4.95.

BABY LEARNING THROUGH BABY PLAY: a parent's guide for the first 2 years. Ira J. Gordon. St. Martin's Press, Inc., 175 Fifth Avenue, New York, N.Y. 10010. 1970. 121 pp. $5.95.

THE BOYS AND GIRLS BOOK ABOUT DIVORCE. Richard A. Gardner, M.D. Science House, Inc., 59 Fourth Avenue, New York, N.Y. 10003. 1970. 158 pp. $7.95.

YOUR CHILD AND HOUSEHOLD SAFETY. Jay M. Arena, M.D. Chemical Specialties Manufacturers Association, Inc., 50 East 41st Street, New York, N.Y. 10017. 1970. 20 pp. 25 cents.

HELP FOR YOUR TROUBLED CHILD. Alicerose Barman and Lisa Cohen. Public Affairs Committee, Inc., 381 Park Avenue South, New York, N.Y. 10016. 1970. 24 pp. 25 cents.

ADVICE TO PARENTS OF A CLEFT PALATE CHILD. Donna K. Wicka and Mervyn L. Falk. Charles C Thomas, 301–327 East Lawrence Avenue, Springfield, Ill. 62703. 1970. 57 pp. $3.25.

THE WORKING MOTHER'S GUIDE TO HER HOME, HER FAMILY AND HERSELF. Alice Skelsey. Random House, 201 East 50th Street, New York, N.Y. 10022. 1970. 247 pp. $6.95.

IN THE JOURNALS

Family stability

The majority of black adults and children in America are in statuses indicative of family stability—that is, most adults are currently married, most families are husband-wife families, and most children are legitimate and live with both parents, according to a study of the trends from the 1890's to the present reported by Reynolds Farley and Albert I. Hermalin in the February 1971 issue of *American Sociological Review.* ("Family Stability: A Comparison of Trends Between Blacks and Whites.") The authors, associate professor of sociology and research associate, respectively, at the University of Michigan, find that in every comparison between blacks and whites, the proportion of persons in the status indicative of family stability is greater among whites.

However, the comparison from 1890 to the present suggests that the relative stability of black families, as indicated by the proportion "currently married" has remained steady. The increasing differences between whites and blacks during this time have been largely due to an increase in the proportion of whites currently married. In general, trends in black and in white families are the same—that is, there has been an increase in divorce and a decrease in widowhood.

The authors attribute the increase in the number of female heads of black families at least partly to the fact that many women are now economically able to maintain their own households instead of being counted as "other relative" in some other household. Although this is a general trend in both white and black families, it is more marked in black families.

Study data show that currently married men of both races have higher socioeconomic status than do single, widowed, divorced men or men whose spouses do not live with them. Moreover, differences between categories of marital status within the same race are much smaller than differences between races. The authors conclude that family instability is associated with somewhat lower levels of life chance variables (education, occupation, and income).

Divorce and children

"It is a truism today that parents should be honest with their children, but parents apparently do not always extend this precept to being honest with their children about divorce," says Paul Bohannan, Ph. D., in an article in the January–February 1971 issue of *The Single Parent.* ("The Six Stations of Divorce.") The author, an anthropologist at Northwestern University, maintains that children should be told ahead of time about the coparental aspects of divorce—including custody, visitation, and the new division of labor in the household—so they can know what to expect and so adjust more easily.

Such aspects of divorce bring problems that are long-lasting and difficult, the author explains, because the child's parents—while divorced from each other—are not divorced from the child.

Since children in divorce miss some of the family culture they would have learned by living in an unbroken healthy home, the author suggests that they be taught purposefully about the companionship, sexual, coparenting, and domestic aspects of marriage. This should be done, he says, without bitterness or hostility and without denigrating or idealizing the absent parent.

Citing the traditional and popular belief that divorce is "bad for children," the author points out that "actually, we do LOT know very much about it." Some children deal with the tensions of divorce by turning to delinquency, he observes, while others react with supercompliance. "The tensions in divorce certainly tell on children," he says, "but the answers the children find are not inherent in the institution of divorce."

The author lists six overlapping experiences that occur in every divorce: emotional, legal, economic, coparental, community, and psychic experiences of separation. He suggests that they are "more painful and puzzling as personal experiences" because society is not yet equipped to handle any of them well.

Parents and TV

The parental role in the child's television experience goes far beyond switching the channel or shutting off the set when the child is watching a possibly harmful program, according to an article by Norman L. Paul, M.D., in the March 1971 issue of *Childhood Education.* ("Invisible Factors in a Child's Reaction to Television.") How the child reacts to violence in a TV program, the author says, may be conditioned as much by the quality of the parent-child dialogue and the child's feelings about himself and his various fears as by what goes on in the program.

Pointing to the confusion of fantasy and reality in the young child's mind, the author stresses the importance of helping the child bridge the gap between the two, not only by knowing what he is watching but by helping him to put it in perspective by talking with him about what he sees.

Because the real life of a real family lacks "the rosy and rarified tranquility of a situation comedy series and the excitement of an adventure series," parents need to demonstrate the value of the real situation by encouraging communication and the frank expression of feelings, the author maintains.

He suggests that long-term effects of the patterns of unreality that come to a child through television may be more damaging than immediate aggressive response to a violent scene: "What happens when the child becomes inured to terrifying and violent scenes on television? . . . Will violence in the real world seem more acceptable and casual and thus decrease the concern individuals have for each other?"

Such questions, he says, bring us back to the parents' role "in providing empathy and a reality input." Granting the need for better programing, he maintains that "it is the communication between parents and children to which

we should be addressing our primary attention and concern."

White and black

Child welfare workers, especially white workers, have to be acutely aware of how they work with black children today, says Crawford E. Burns, M.S.W., director of community services at the Children's Village in New York City, in the February 1971 issue of *Child Welfare*. ("White Staff, Black Children: Is There A Problem?") He maintains that the mistrust of whites by black children is not a new problem, but is one that is manifested openly today instead of being suppressed.

Pointing to the tendency of children in institutions, regardless of race, to resent authority and "seek out the cracks in each worker's defense mechanisms," the author says that many black children today have learned how to manipulate the guilt feelings their white workers have about the injustices suffered by black people. He warns white institutional workers against practicing "discrimination in reverse" and not setting the limits that children need and want. Children are children first and "black children" second, he says.

Black children must be helped to express their own group identity, the author says. However, he points out that the term "black identity" is an oversimplification, meaning something different to each black person, depending on his own background, personality, and family attitudes.

The author stresses the importance of examining one's pet prejudices, "racial or otherwise," in working across racial lines. As a medium for such examination he advocates interracial sensitivity training groups for agency staffs. Such groups, he says, can help white and black workers to achieve a better understanding of one another as well as the children to whom they must relate. He also recommends group discussions between staff members and children.

READERS' EXCHANGE

GALLAGHER: the black experience

I was impressed by Ursula Gallagher's article because it provides a clear picture of the national situation in an area of urgent need, and suggests some directions for solving the problem. ("Adoption Resources for Black Children," CHILDREN, March-April 1971.)

However, at our agency, Homes for Black Children, we do not believe our success has been determined by recruitment techniques. Naturally families had to be recruited, but recruitment was easy for us because the black community could identify with the name of the agency. Being a black agency was also helpful in reducing anxiety in potential adoptive parents, particularly when they found a predominately black staff. This lessening of anxiety enabled them to stay in the process and use the process more effectively. The black community in Detroit does not see Homes for Black Children as a "white man's resource."

My point is that established agencies that have not been successful in obtaining and keeping black applicants are likely to find increased recruitment a waste of time and money. A great deal of the recruitment that has been done for black families has been aimed at eliciting sympathy. This is completely ineffectual. Identifying the simple truth that black families have always "adopted" at a much high rate than white families is important. The fact that these arrangements have normally been informal indicates more need for education than for recruitment. It also indicates a need for change within agencies.

Suggesting a need for change in agencies supports Miss Gallagher's statement that new methods of approaching black families must be developed. I believe that large percentages of people involved in administering, planning, and delivering adoption services are not fully aware of the meaning of the black experience in America. It is completely unrealistic to expect black families to respond to the agency, regardless of process, as white families respond.

Agencies must reach out to recruited families with interest and support or the majority of black families recruited will be lost. Most white families expect to be approved for placement and have great difficulty understanding or accepting not being approved. Many and probably most black families anticipate rejection and frequently withdraw their applications to avoid rejection. This difference makes the need for different methods obvious.

The problem of black children waiting for adoption is one of the most urgent social problems in America. We are pleased that the Children's Bureau is helping to identify the magnitude of this problem, and hope that it will continue to seek solutions.

Clarence D. Fischer
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A slighted resource

The title of Ursula M. Gallagher's article, "Adoption Resources for Black Children" implied many potential adoptive resources for black children.

Miss Gallagher is to be commended for the excellent job of compiling and presenting the multifaceted problem of adoption placements for black children. Her article provides an excellent resource overview of adoption services

and innovations. However, it did not entirely fulfill my expectations.

My expectations were based on my view of the Children's Bureau as an advocate for children and on my experience in an agency which subsidizes families so that they can adopt children. In reading the article I felt that Miss Gallagher's treatment of subsidized adoptions did not give this resource the importance that it deserves. I do not mean to negate the effectiveness of the newer recruitment techniques, the liberalized requirements for adoption nor the practice of bringing the service to the community as did the Los Angeles County Department of Adoptions when it opened an office in Compton, Calif. However, there is a fact of life that heavily influences the ability of any family, particularly a black family, to adopt—*economics.*

A study reported in an unpublished master's thesis, "Adoption and the Middle-Class Negro," by G. Kennedy et al., presented to the faculty of the School of Social Work, University of Southern California in June 1967, found that many black families felt that educational and cultural goals for their children would be limited if they accepted economic responsibility for a larger family.

Maybe it was not within the scope of Miss Gallagher's article to give more attention to subsidized adoption. However, I would like to see an article in CHILDREN that treats this topic specifically. By virtue of the magazine's position of national leadership as an advocate for children, such an article would give impetus to more widespread use of subsidies to help families adopt black children.

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County Department of Adoptions
Compton, Calif.

PRESCOTT and JONES: A fair contrast?

In experience, observations, and thinking I am in basic accord with the points made by Elizabeth Prescott and Elizabeth Jones in the March–April issue of CHILDREN. ("Day Care for Children—assets and liabilities"). However, in reading the article, at times I had the feeling that they unintentionally were contrasting a model family with a mediocre center. To be sure most day-care centers are mediocre, but alas, most of the children attending them come from anything but ideal families.

Certainly, group day care is no panacea for the deprived, but the essential elements that can be part of it should be stressed.

For instance, teachers who care about the children are a necessity where children are to be in group care all day. In addition, they must have skill, knowledge, and self-awareness if they are to be effective. We Americans tend to think that developing the intellect is the only aspect of education that takes training. That perceptiveness, imagination, and self-discipline are involved in the effective teaching of young children is too often overlooked. Teachers must have a natural aptitude for acquiring these skills, but developing them takes time.

In this day when many people hope that the provision of day care on a mass scale can become a profit-making venture, the need for smallness, informality, and flexibility in a day-care program cannot be overstressed. Big buildings are not for little children.

The problem of how to promote the kind of day care that supports rather than subdues the human spirit is a serious one. Neither the public at large nor those in power have accepted the cost of good day care, and the ultimate price of poor day care is completely overlooked. The tendency is to believe that the day care of children should be cheap—and I use the word advisedly. There is little appreciation of the worth of a skillful nursery school teacher, nor of the need for small groups.

We must somehow promote stronger conviction in those responsible for the young. Individualization and privacy can be achieved, even in group settings, where there is a will. For instance, children can be separated by screens at naptime and can be allowed to play quietly if they do not need the sleep.

There can and should be more creative experimentation. The Day Nursery Association of Cleveland has a small but excellent family day-care program. It costs as much as good group care and has educational and social elements built in. It has as well flexibility, nearness to home, and care for children of widely different ages. It has opened wider horizons and career opportunities to women with a capacity for mothering who can now work in their own homes.

The basic problem in building a day-care program is to arouse enough concern to assure that balance can be achieved. I would agree with the authors that good parent-staff communication can lead to creative ideas and is imperative.

Eleanor M. Hosley
Executive Director
Day Nursery Association of Cleveland
Cleveland, Ohio

collected readings

PSYCHOLINGUISTICS: selected papers. Roger Brown. The Free Press, 866 Third Avenue, New York, N.Y. 10022. 1970. 392 pp. $8.95.

TROUBLED CHILDREN IN A TROUBLED WORLD. Edith Buxbaum. International Universities Press, Inc., 239 Park Avenue South, New York, N.Y. 10003. 1970. 341 pp. $10.

THE BLACK FAMILY: essays and studies. Robert Staples. Wadsworth Publishing Co., Inc., 10 Davis Drive, Belmont, Calif. 94002. 1971. 393 pp. $4.95.

POPULATION, EVOLUTION, AND BIRTH CONTROL. Garrett Hardin, editor. W. H. Freeman and Company, 660 Market Street, San Francisco, Calif. 94104. 1969. 386 pp. Cloth $6, paper $2.95.

LIFE HISTORY RESEARCH IN PSYCHOPATHOLOGY. Edited by Merrill Roff and David F. Ricks. University of Minnesota Press, Minneapolis, Minn. 55414. 1970. 321 pp. $10.

THE DISADVANTAGED CHILD. Joe L. Frost and Glenn R. Hawkes, editors. Houghton Mifflin Co., Educational Division, News Bureau, 110 Tremont Street, Boston, Mass. 02107. 1970. 499 pp. $5.95.

FROM CHILD TO ADULT: studies in the anthropology of education. John Middleton, editor. The Natural History Press, Doubleday & Co., Inc., 277 Park Avenue, New York, N.Y. 10017. 1970. 355 pp. $8.95 hardbound, $3.95 paper.

U.S. Government Publications

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CAMPING OPPORTUNITIES FOR DISADVANTAGED YOUTH: a planning and coordinating guide. President's Council on Youth Opportunity in cooperation with HEW, OCD, Children's Bureau. 1971. 80 pp. 75 cents.

This publication is a manual for planning and coordinating resources to provide children and youth opportunities for adventure and experience in year-round camping. It also provides directories of Federal resources to help in designing and operating such programs for disadvantaged children and youth.

IDENTITY IN A TROUBLED WORLD: report of a conference, June 20–21, 1968. HEW, OCD, Children's Bureau. CB Publication 469. 1970. 60 pp. 65 cents.

This publication summarizes the 2 days of discussions between 25 young people and adults of various racial and ethnic backgrounds brought together by the Children's Bureau to probe the difficulties young people have today in achieving an identity that makes sense to themselves. It presents many different points of view and one point of unanimity: youth wants "in" as a contributing member of society.

CHILD WELFARE TRAINING GRANT AWARDS: fiscal year 1970. HEW, SRS, Community Services Administration. 1970. 11 pp. Single copies free from CSA.

Lists the 77 schools of social work and 19 other institutions of higher learning awarded teaching grants (totaling $2,876,854), traineeships ($2,823,119), or grants for short-term training projects ($99,968) during fiscal year 1970.

WIN FOR A CHANGE: through the work incentive program. U.S. Department of Labor, Manpower Administration. 1970. 26 pp. 60 cents.

Describes the work incentive program for recipients of aid to families with dependent children (AFDC) by following a participant through training to job placement and points out that the major obstacles to greater achievements have been difficulty in providing enough training spots for all the people in the AFDC program who want to prepare for employment and the shortage of good child care facilities.

AN ANNOTATED BIBLIOGRAPHY ON CHILDREN. HEW Department Library, for the White House Conference on Children. 1970. 75 pp. Free from the White House Conference on Children, Box 19, Washington, D.C. 20044.

Lists and annotates 500 recently published materials related to topics for the 1970 White House Conference on Children—individuality, learning, health, parents and family, communities and environments, and laws, rights, and responsibilities.

HEW refers to Department of Health, Education, and Welfare; OCD, to Office of Child Development; PHS, to Public Health Service; SRS, to Social and Rehabilitation Service; OE, to Office of Education.

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